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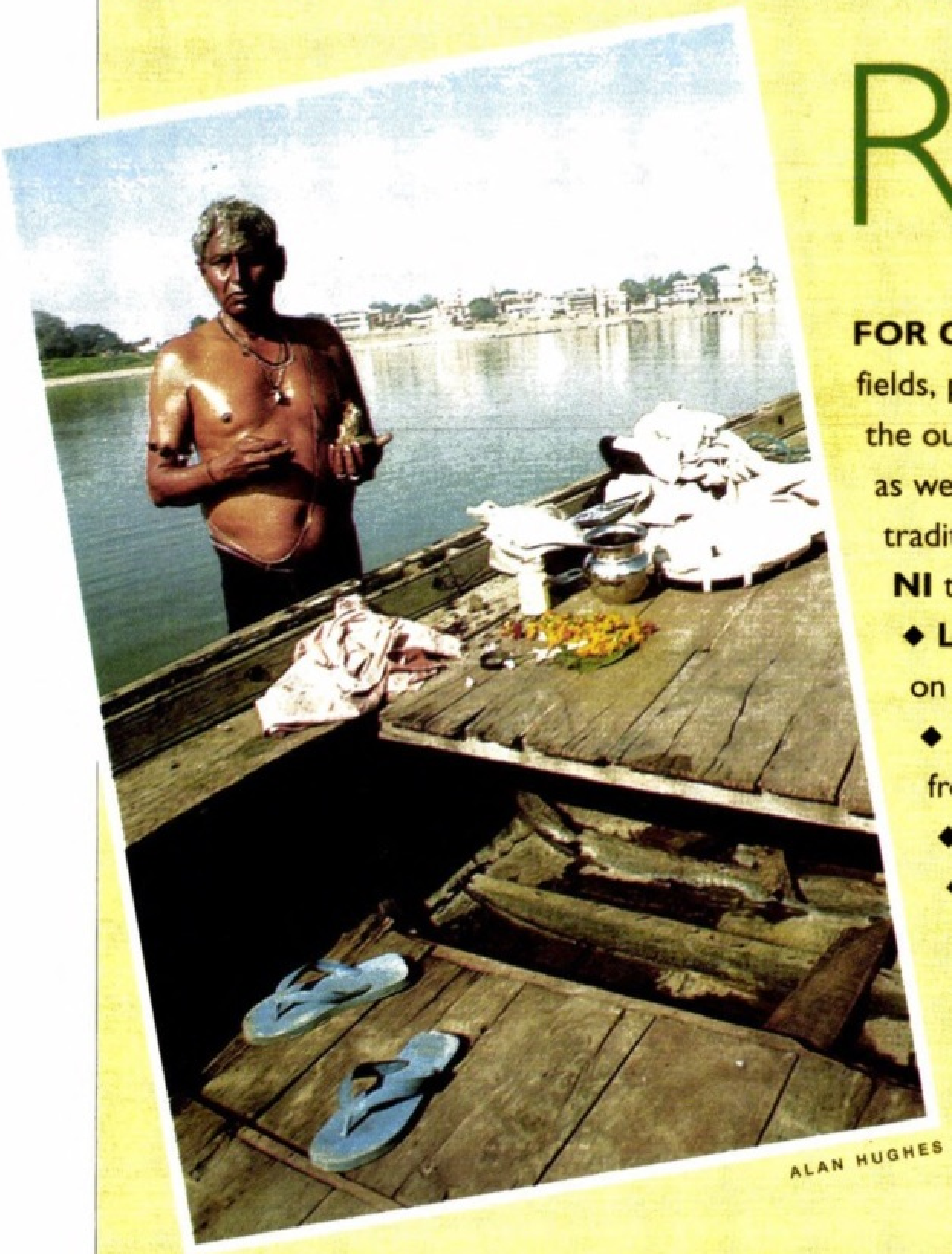

ALAN HUGHES

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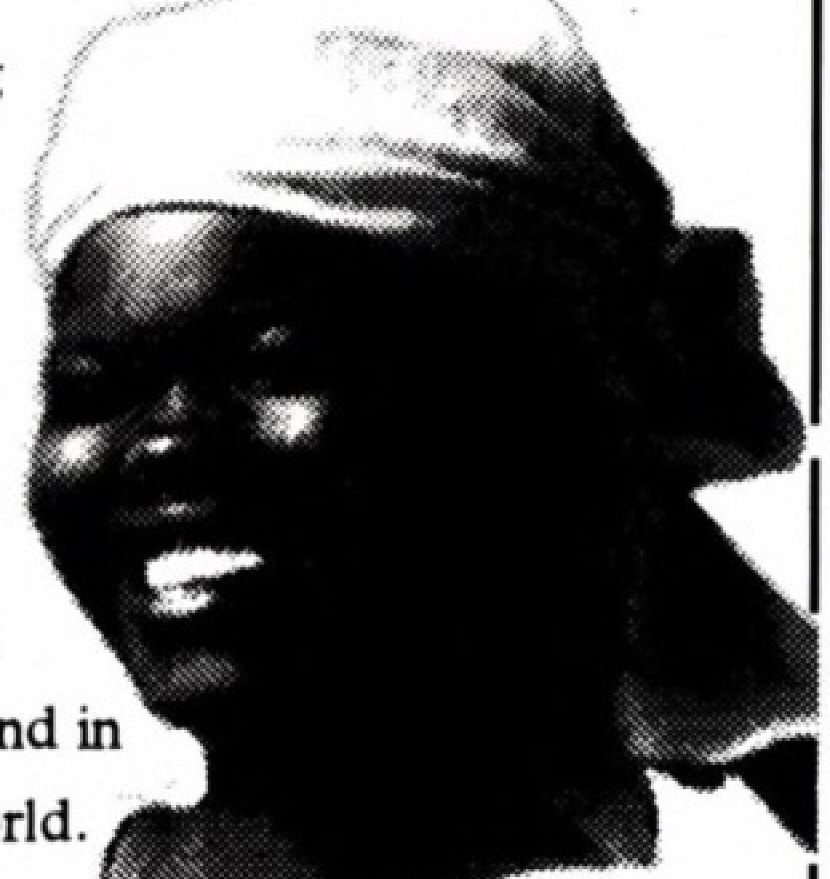

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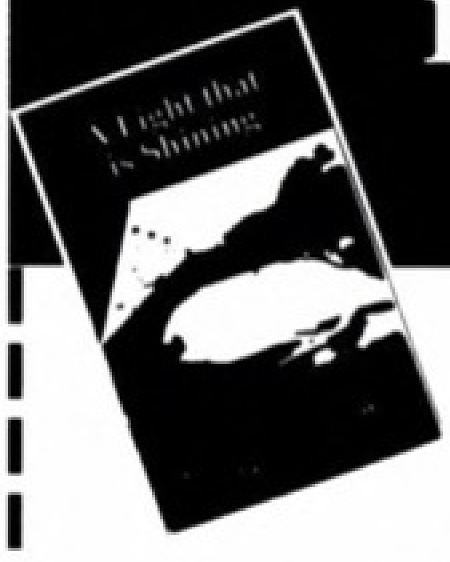

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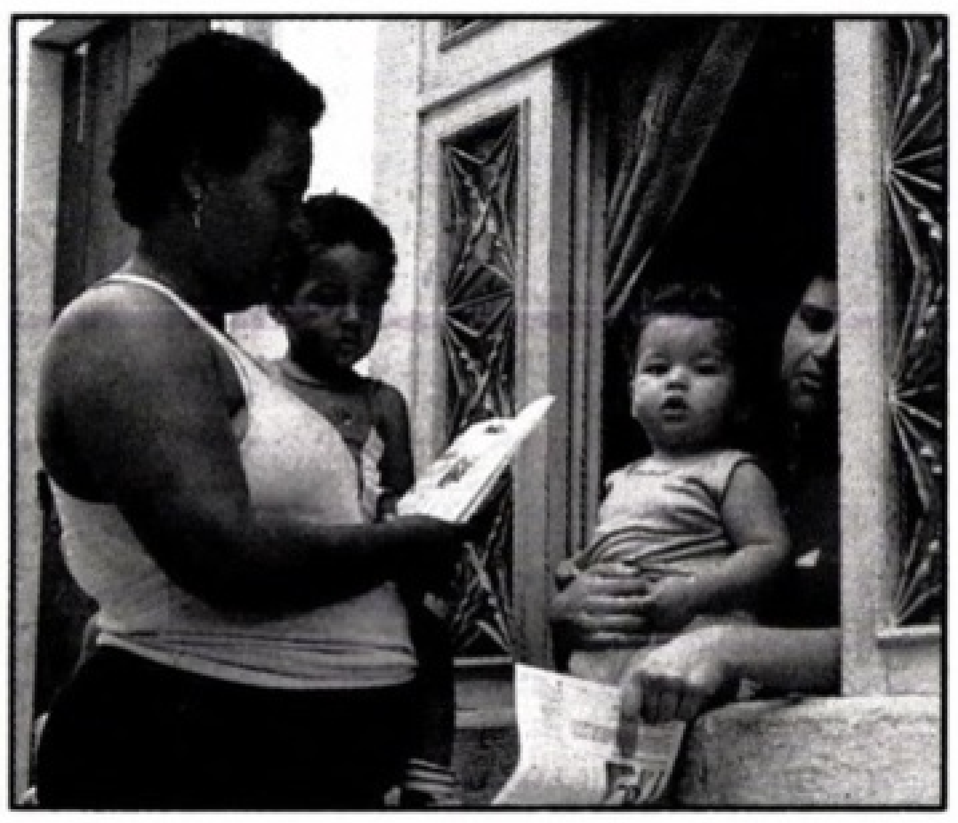

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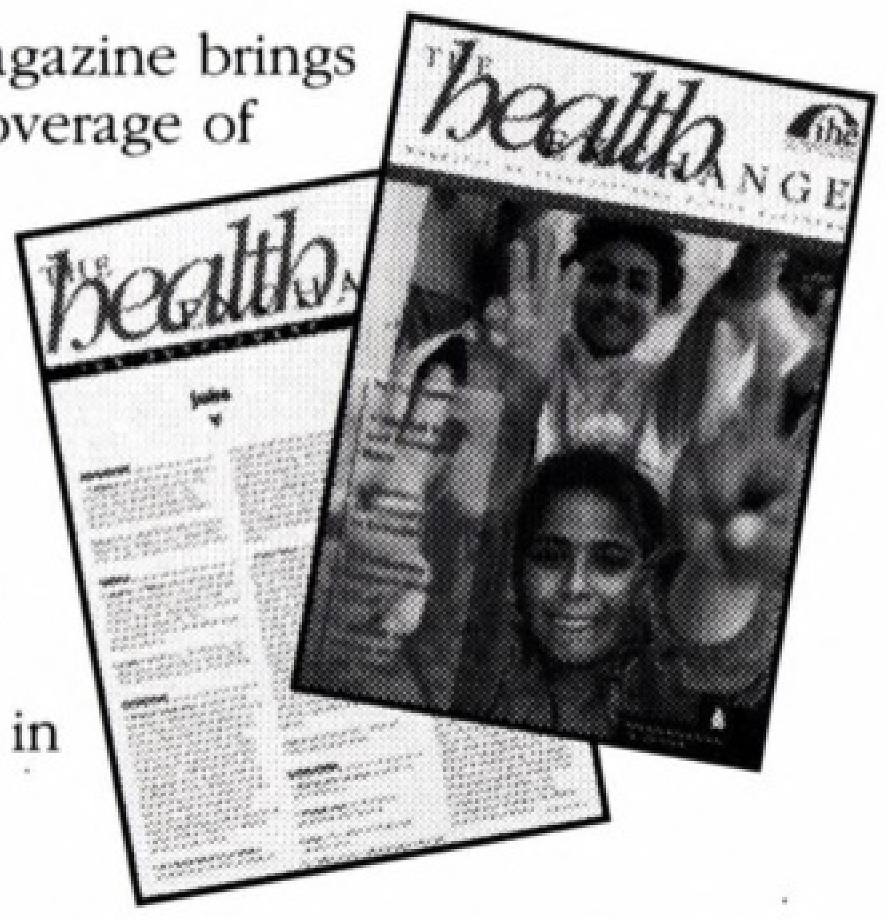

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MAGAZINE DESIGNED BY **ALAN HUGHES**
FRONT COVER BY **ANNE CAKEBREAD**

THIS MONTH'S **THEME**

Medicine

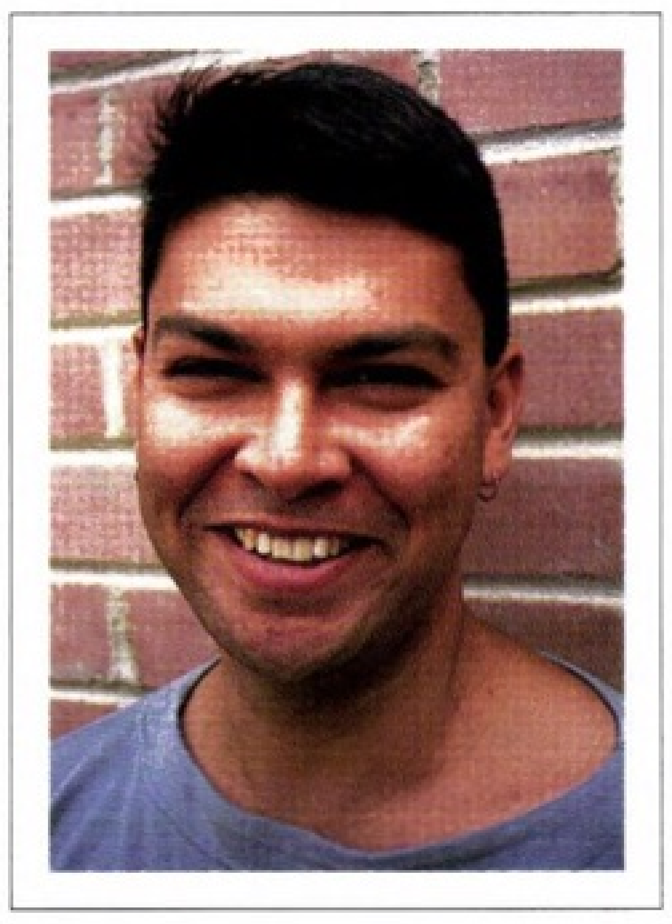
FROM THIS MONTH'S **EDITOR**

THE DOCTOR KNELT at eye-level with my genitalia. My father, surprised, remarked that his little boy was growing up, a reference to my new-sprung pubic hair. Before the doctor came I had asked my mother – a former nurse – if I would have to take my pyjamas off. I had prepared to die of embarrassment.

Strangely, the doctor's concern dispelled all that and the examination took on a curious air of display, as though my little life had shrugged off its cares and distractions and stood naked under a spotlight, awaiting judgement.

'It's acute appendicitis,' said the doctor. Magic words. Days after the operation I would tell my friends at school: 'It was really *acute*.'

In no time I was whisked off, still in my pyjamas, to the local nursing home by two very worried parents. They were justifiably worried. Before I came into this world a legendary uncle had died of a ruptured appendix. He had been a handsome young man with pomaded hair. On my way to the nursing home I wondered whether one day my nieces and nephews would look at a sepia photograph of an uncle whose life had been tragically cut short. You could say my fantasy life was pretty dramatic back then.



Once settled in my new bed I resisted all efforts at sedation. The doctor who would be operating on me came to have a look – he was a broad man with great jowls who was more interested in talking to my parents than to me. Eventually, when I refused to go to sleep, a nurse tempted me with a walk around the place, and before I knew it I had walked into the operating theatre and was being counted out.

Afterwards I would beg for sedation as the pain became too much. A steady stream of relatives, including a glamorous cousin who had just become an air hostess, came visiting with gifts and nothing but praise. This warm glow lasted until my stitches came out.

Then I saw with horror the scar – four inches in length, just under my navel. It was red and gross like an oversized worm. Damn, I'd never make it as a film star because I wouldn't be able to take my shirt off. I informed the doctor, quite solemnly, that he had ruined my sex appeal. My parents were disappointed too that I had been split apart for a fairly common surgical procedure. 'He's nothing but a horse doctor,' my mother muttered under her breath.

Since then I have encountered much doctoring, good and bad, but it is the memory of my operation that prompted me to do this magazine. Of course this issue is packed with the usual, wide-ranging **NI** mix and there's actually very little of 'a funny thing happened on my way to the hospital' in it. So I thought I'd get it in here!

The scar will always be with me. It's become quite a cherished part of my anatomy now. It marks the spot where medicine entered into me and saved my life.

Dinyar Godrej

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for the ***New Internationalist*** *Co-operative*

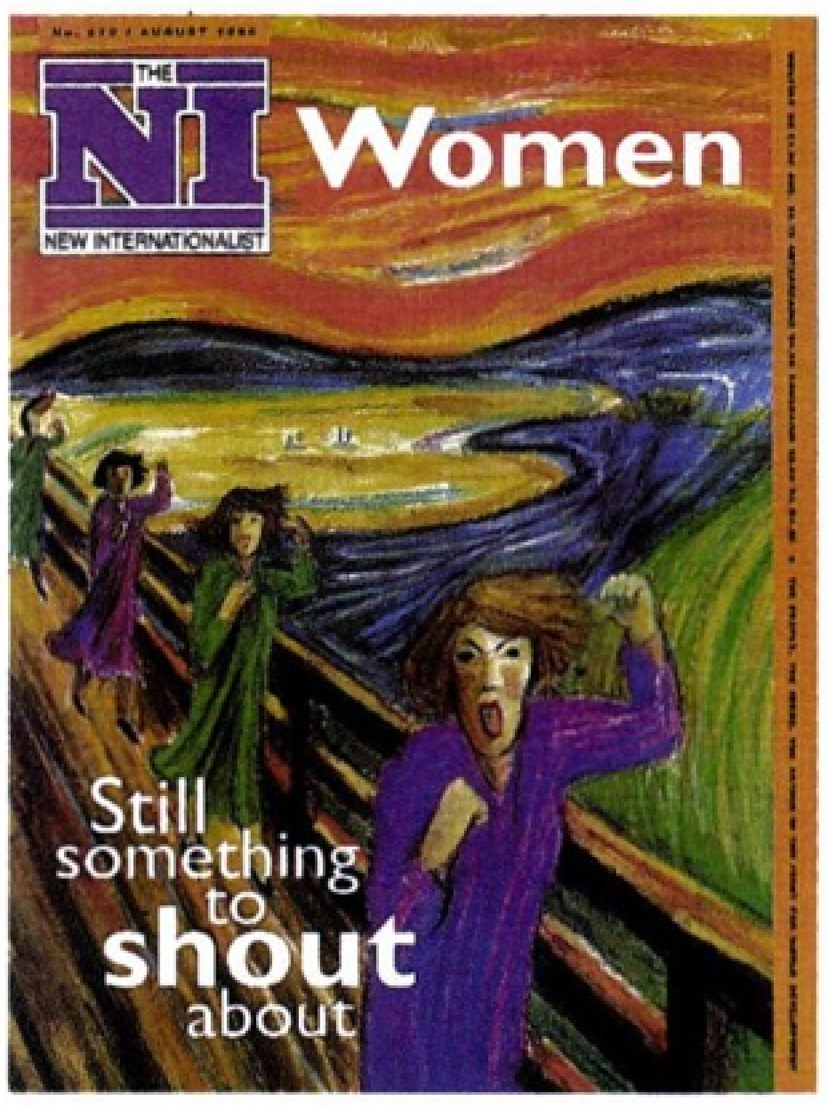
Letters

The New Internationalist welcomes your letters. But please keep them short. They may be edited for purposes of space or clarity. Include a home telephone number if possible and send your letters to the nearest editorial office. The address is inside the front cover.

Happy ladies

Following this month's edition on ***Women*** (**NI 270**), I trust that the balance of your magazine will be maintained by issuing a corresponding edition featuring men.

Just as there are rotten Gents who shout at and beat their ladies, so also are there females who nag and humiliate their menfolk – one assaults the body, the other the soul. It would be naive to assume that one sex has the monopoly of virtue.



In this part of the country there is little tangible evidence to suggest that our ladies live less fulfilled and happy lives than the men and here, as elsewhere, females have the longer life expectancy.

I doubt whether the angry persons portrayed on the cover will do much to enhance the love and respect between the two complementary sexes.

Richard Morley
Leominster, England

Double-think

Charlie Warshawski's *Country Profile* of Chile (**NI 270**) includes a piece of gratuitous bias. The map illustrating the regional context indicates the Falkland Islands only by their Spanish name 'Malvinas'. Yet other names are in English. I have to assume that the use of the Spanish name is intentionally geo-political and that it indicates support for the imperialist, colonialist, chauvinist claims of Argentina against the political and human rights of the Falkland islanders to self-determination.

This suggests a disturbing level of 'double-think' in an article which is critical of military influence in South America. Popular opinion in Argentina has been deliberately misled and misinformed about the Falklands for generations, and continues to be manipulated by some Argentine politicians for their own ends – certainly not for the sake of justice to the Falkland islanders.

By opting for the name 'Malivinas' without qualification, I fear you may have succumbed to fashionable political correctness, instead of genuine concern for the honest truth, however unpalatable it may be to some of your regular supporters.

Martin Dodds
Sedburgh, England

Practical dreams

Your issue ***Back to the Future*** (**NI 269**) highlighted the impossibility of forecasting an ever-changing, unknowable future – but that does not mean that we can afford to stop thinking about the sort of future we want.

Nor is it enough to dream. We have to be practical. Since none of our economic and political systems – socialist, communist or capitalist – is able to solve even this most elementary equation, there must be a fundamental flaw in our assumptions; but we have shut our communal minds and refused to ask what it is. To offer any alternative is regarded as heresy.

We cannot forecast what *will* be done but we have the capacity to reason and to determine what *needs* to be done and how we may do it. If we are to have a future at all, let alone a desirable one, we have to create it ourselves and we can only do that by questioning the political, economic and social consensus in which we are trapped.

Melvin Chapman
Bath, England

Not the IMF

Please stop blaming constantly and solely the IMF for the debt spiral and the reduction of the Majority World's spending on healthcare and education. Although the IMF made mistakes in these areas (eg fee-based primary education) which are slowly being corrected, governments themselves are often to blame.

Every year at the annual donors' meeting, African governments ask for and receive between $250 million and $1 billion in new money, most of which will have to be repaid. These funds are for a general balance of payments support and for a wide range of small projects.

Unfortunately, a lot of governments prefer to cut their already low spending on health and education rather than reduce their military spending, which is in excess of that of the industrialized countries (as a share of GDP) and is used to buy the most sophisticated and expensive equipment (there you should blame arms-exporting countries).

At the same time many of the poorest countries in Africa spend $10 million or so every election year to import hundreds of new cars to distribute to officials for political support.

Denying the scale of both the military spending and the corruption will be less effective in reducing poverty than would pressure on Majority World governments to focus on developing their countries and not on maintaining themselves in power.

Emmanuelle Moors de Giorgio
London, England

Narrow charity

Stan Knafler raised a very good point in his letter (**NI 269**) which you appropriately headed

Ethics

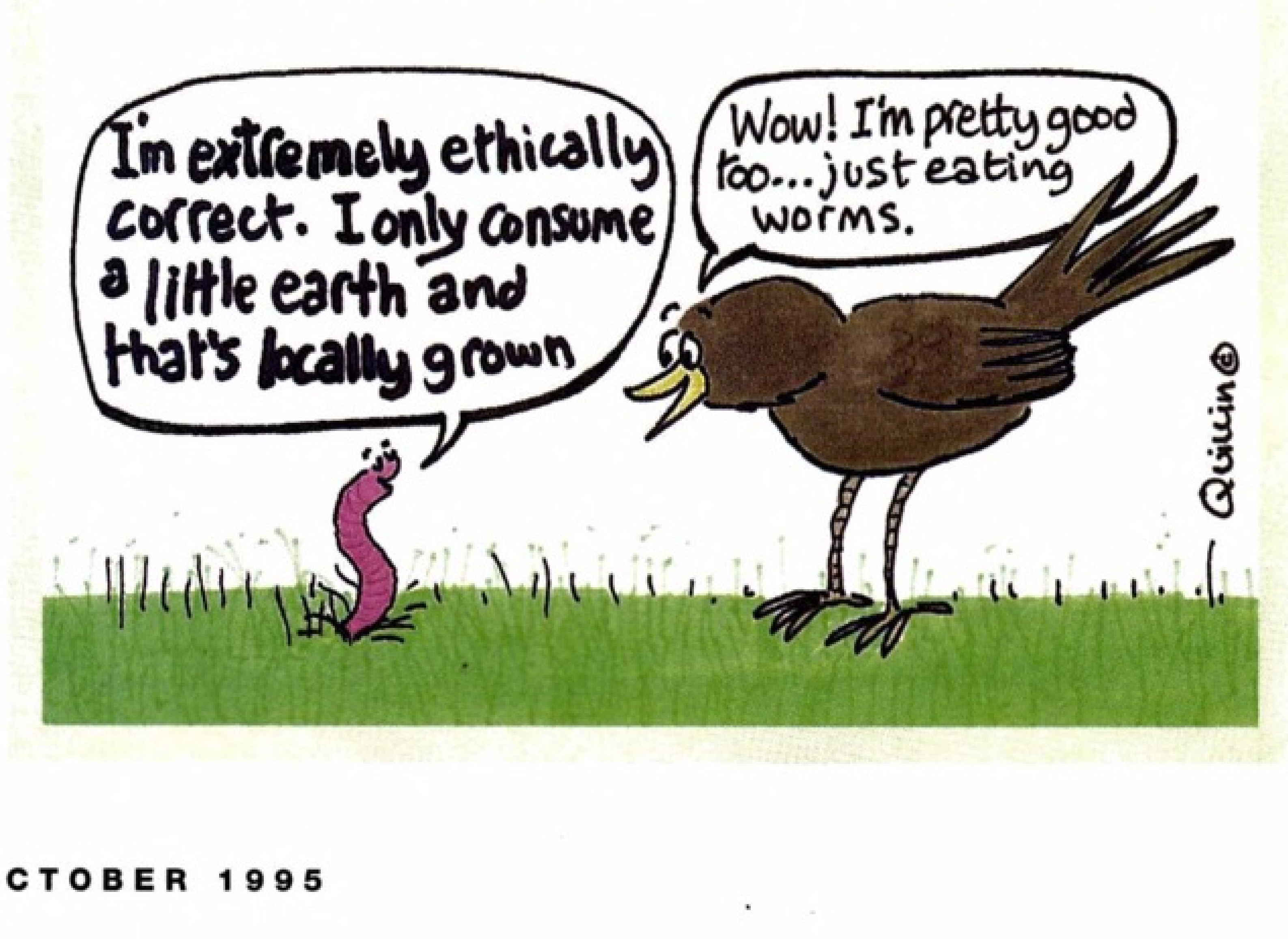
While I share Debbie and Peter Wakeham's opposition to capital punishment (*Letters* **NI 269**), I am unsure whether boycotting the US is the best policy.

What if one were buying sunflower seeds and the choice was between the US and China, a country with a worse human-rights record which also maintains the death penalty?

It would be more consistent to avoid all countries with capital punishment but then there are other reasons for not buying from foreign countries which have very good human-rights records. Living in Britain, I do not buy apples from Aotearoa/New Zealand, despite the fact that it has one of the best human-rights records in the world because it is not ecologically sound to move products over such long distances.

In Britain, the *Ethical Consumer* provides information on the ethical records of manufacturers and retailers as well as information on alternatives to some consumer goods.

Katharine A Gilchrist,
Canterbury, England


I'm extremely ethically correct. I only consume a little earth and that's locally grown
Wow! I'm pretty good too...just eating worms.
Quillin ©

VIV QUILLIN

'Donor's dilemma'.

In the past I have written to a number of charities explaining that I feel unable to donate to them while they continue to spend money in countries whose governments and major ethnic groups commit human-rights abuses against minorities.

The particular example I quoted was Bangladesh, where the Jumma and other hill tribes were being subjected to attempted genocide by the armed forces of Bangladesh and Bengali settlers.

My argument was that every dollar spent on the Bangladeshi people by charities was one dollar less that their Government needed to spend on them – money that would then be spent either on the military or on shipping more settlers to the Chittagong Hill Tracts.

The response from charities was disappointing. They wrote back attempting to justify their actions but seemed unwilling or unable to take a wider view of events, seeing only their own narrow band of activities. Before parting with our hard-earned cash we should consider the end result of donating to a particular organization.

Denis Underwood
Bracknell, England

Rich meet poor

Your issue on the African village (***Heart and Soul*, NI 268**) raises the issue of tourism and travelling. How can one, coming from an obscenely wealthy country, go for a holiday in a country where people are struggling to survive?

Paradoxically, there has to be a way whereby people can meet and share their humanity... We may like to know how others are living, but do people from poorer countries want to be told how well off we are compared to them? As Chris Brazier puts it: 'Awareness of your own poverty becomes more painful when someone else's relative prosperity is staring you in the face...'

Véronique Bell
Taree, New South Wales, Australia

The views expressed on the letters page are not necessarily those of the New Internationalist.

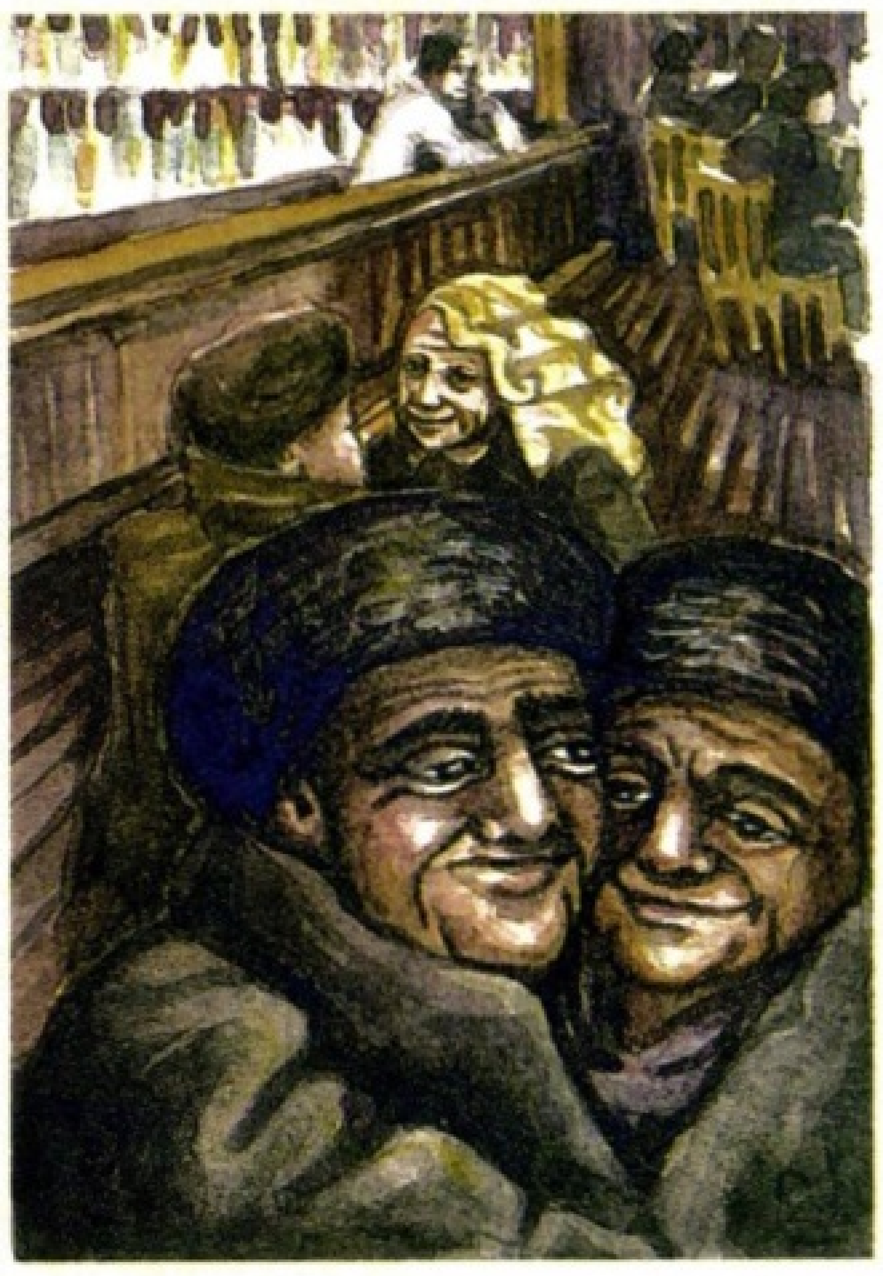
LETTER FROM **THE RUSSIAN ARCTIC**

Love and pies at the Usinsk Café

Two bears are embracing on the dance-floor. The smell of pizza is everywhere. Olivia Ward comes in from the cold and discovers a sanctuary.

THE AIR HAD a clammy chill, though the small space of the room and its wood panelling made for an illusory cosiness, like a welcome bomb-shelter in a time of heavy siege. But the smell in the air was of pizza, noisy Western rock music overwhelmed the conversations and a bar lining one wall was glittering with bottles of imported wine, beer and liquor.

After days in this remote Arctic oil town that made the eyes water with bitter cold, smog and sheer ugliness, I had somehow found its hidden heart.



MIRIAM McCURDY

Each day I had talked to embittered oil workers, ruined fisherfolk and suicidal pensioners who could neither live in nor leave this land that communism built and fickle fate abandoned.

Returned to my bleak hotel after those interviews I chopped stale black bread with a blunt knife, drank my precious supply of packaged orange juice, and wondered that all life in the town didn't end on some interminable night when the dawn carelessly forgot to pull aside its curtains for even an hour.

'What you need,' chuckled a Norwegian friend, 'is the Usinsk Café'.

Without argument I followed him through long, featureless blocks of high-and low-rise buildings until at last we shoved our way through a doorway marked only by a light-bulb.

It was too cold to remove our coats and I wondered if my colleague, an experienced northman, would be embarrassed at the sight of me eating pizza in gloves.

'Pizza, or pizza?' joked the waitress, a cheerful young woman who doubled as a disc-jockey and bartender. Some clever Arctic entrepreneur had nabbed a fast-food franchise and proudly transported the frozen pies direct from cosmopolitan Moscow.

Expecting the worst, I nodded. But as my teeth did battle with the crust a few minutes later my spirits unaccountably rose.

Through the smoke I squinted around me. There, on the tiny dance floor, two large bodies – were they bears or humans? – lumbered together to the trilling tunes of 'Lady in Red'. Their faces, round and androgynous under fur hats, were blissful. They were, it was obvious, very much in love.

Another couple joined them. The female partner had left her head recklessly bare to show off a mass of dyed blond curls. But her companion stared at her with undisguised adoration, ignoring her lined and weathered skin.

Behind me in the corner yet another stolid couple sat oblivious of all around them, his hands grasping her wrists under the sleeves of her heavy coat.

Never impressed by public displays of affection, I felt a lump in my throat. None of the lovers here was young, none was beautiful by the Hollywood standards that now obsess Muscovites. And they were not casual pickups that would finish the night in my hotel, where the vicious arguments of the sex trade echoed into the wee hours.

I was transported back in history to the desperate days of Stalin's camps, where many of the wilderness settlements had their beginnings. Places where brutality and starvation were daily fare, and survival meant sinking to the lowest common denominator.

But there too human affection survived. Women spoke of fingers touching through barbed wire, moments stolen in the shadow of guardhouses. 'The most important thing was exchanging words to affirm that we were still human beings,' said one.

Poetry was written and love letters carefully buried. And friendship too managed to survive, with astonishing bursts of compassion appearing like flowers from the frozen tundra.

'People come here to celebrate,' said the waitress, snapping me back to the present with amusement. 'Yes, even here we remember an anniversary or a birthday.'

She was laughing without rancour. This was an oasis, not a place to talk about the realities of life. Unpaid wages, burgeoning pollution, declining prospects, were all left behind at the door as those terrible conditions were blotted out for a minute or two.

Hardship was a condition of life, so what was there to discuss? In moments like these, however stark to an affluent outsider, the spirit was somehow restored.

Then the lights flickered discreetly and a kind of shock ran through the fuggy dimness. Eyes came back into focus and a look of hard awareness returned, identical with the expressions I had seen on the streets. Shoulders squared, the guests filed out into the breathless cold to face what had to be faced.

Closing time at the Usinsk Café. ■

Olivia Ward is bureau chief for the *Toronto Star* in Moscow.

Update

CHILD LABOUR

Carpet mafia

Campaigner killed for speaking out

THE BODY OF IQBAL MASIH was left lying outside the Police Headquarters in Lahore for 16 hours following his murder, according to Ehsan Ullah Khan, President of the Bonded Labour Liberation Front (BLLF).

Until 1993 Iqbal Masih (pictured below) had worked for 12 hours every day knotting carpets. He was one of six million child workers aged under 14 in Pakistan, half a million of whom work in carpet factories. Then he campaigned relentlessly to raise the awareness of the world to the plight of his fellow child-bonded labourers. He worked with the BLLF, which demands protection for workers and the full implementation of Pakistan's Bonded Labour System (Abolition) Act of 1992. This has been largely ignored by loom owners and the so-called 'carpet mafia'.

Initial reports suggested Iqbal had been murdered by a farm labourer, Mohammed Ashraf. Ashraf allegedly fired at Iqbal and killed him. However, following a post-mortem report, the Director of the International Forensic Programme of the US-based Physicians for Human Rights stated that 'further investigation is clearly necessary to resolve the discrepancies between the pattern of injuries and the alleged circumstances of the attack'.

Since the death of Iqbal there has been increased intimidation of those who question the carpet industry. Zafar Yab Ahmed, a journalist investigating bonded labour for *The News*, and Ehsan Ullah Khan of BLLF have been arrested and charged with sedition and collusion with Indian intelligence agents, who are accused of setting up a 'plan to exploit the murder of Iqbal Masih with a view to causing recurring financial loss to Pakistani business interests abroad'.

BLLF offices have been raided across Pakistan and four of their members arrested. Iqbal's family has been constantly harassed and 13 of them have been arrested – including his mother and sister.

The BLLF Chairperson in Britain, Shahid Dastgir Khan, called for an impartial and independent inquiry into Iqbal's murder and reiterated BLLF demands. To date, the Government of Benazir Bhutto seems unwilling to concede these demands, preferring instead to attempt to discredit those who seek to expose the inhumanity of the carpet industry in Pakistan. ■

Paul Donovan

ANTI-SLAVERY INTERNATIONAL

Letters expressing concern regarding Iqbal Masih's death and the treatment of the Bonded Labour Liberation Front should be addressed to Pakistan's High Commissioner or Ambassador in your country.

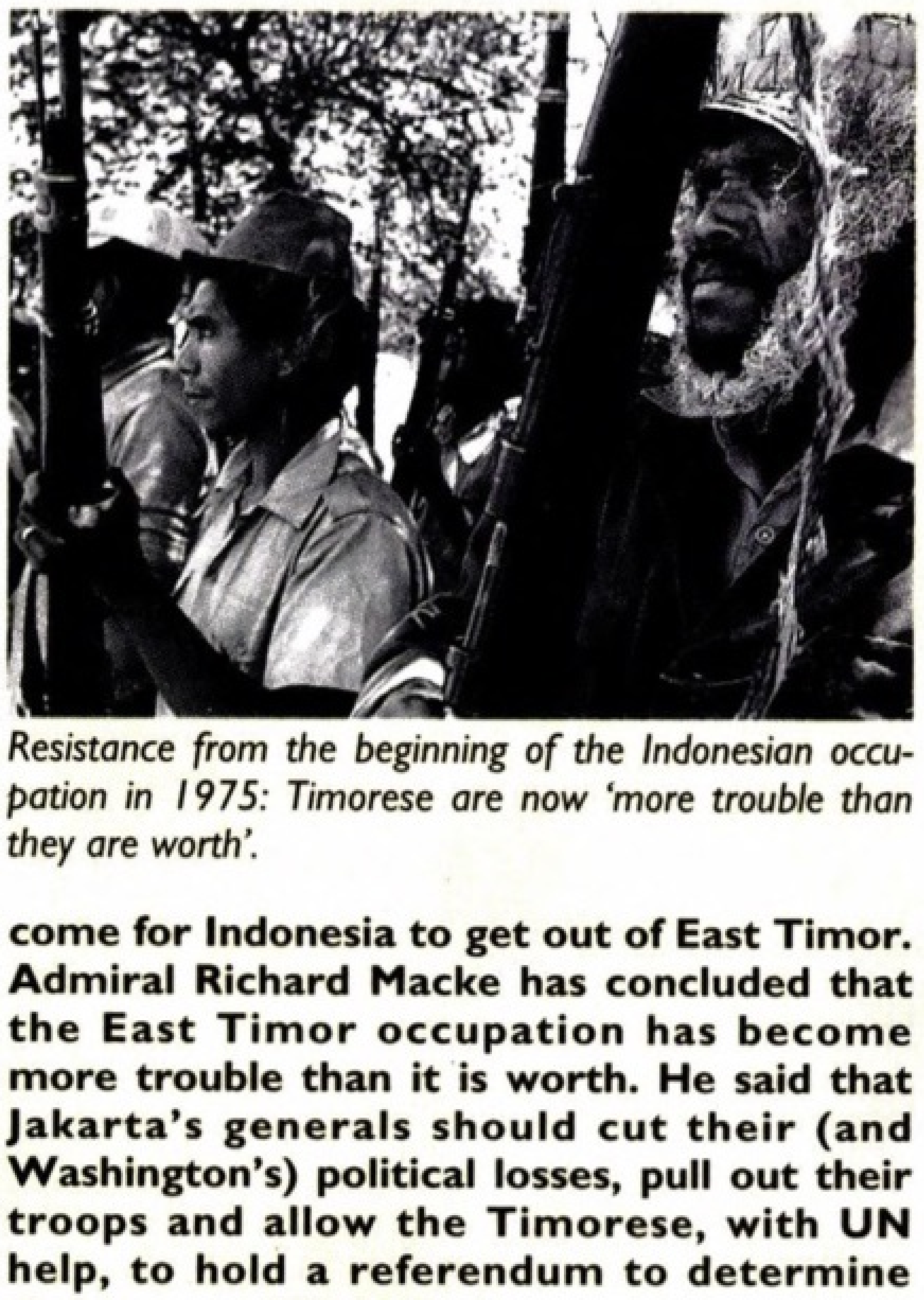
Patrimonial loot

GUATEMALANS ARE UP in arms amid reports that their national archive has been looted by the wife of the collection's director. Maria Elisa Rohrmoser de Gil was arrested in New York for selling documents allegedly stolen from the General Archive of Central America. Rohrmoser's husband Julio Roberto Gil Aguilar was fired, though no charges have been filed against him. When his replacement, Mercedes Elizabeth Flores Garcia, tried to retrieve the inventory stored in the archive vault, she discovered that only Gil Aguilar, whereabouts unknown, has the combination.

Time, vol 146, no 2

Timor shift

IN A SEISMIC political shift that augurs trouble for General Suharto, the Commander-in-Chief of US Pacific forces has privately told Congressional officials that the time has come for Indonesia to get out of East Timor. Admiral Richard Macke has concluded that the East Timor occupation has become more trouble than it is worth. He said that Jakarta's generals should cut their (and Washington's) political losses, pull out their troops and allow the Timorese, with UN help, to hold a referendum to determine their own political future.



PENNY TWEEDIE

Resistance from the beginning of the Indonesian occupation in 1975: Timorese are now 'more trouble than they are worth'.

The Nation, vol 261 no 3

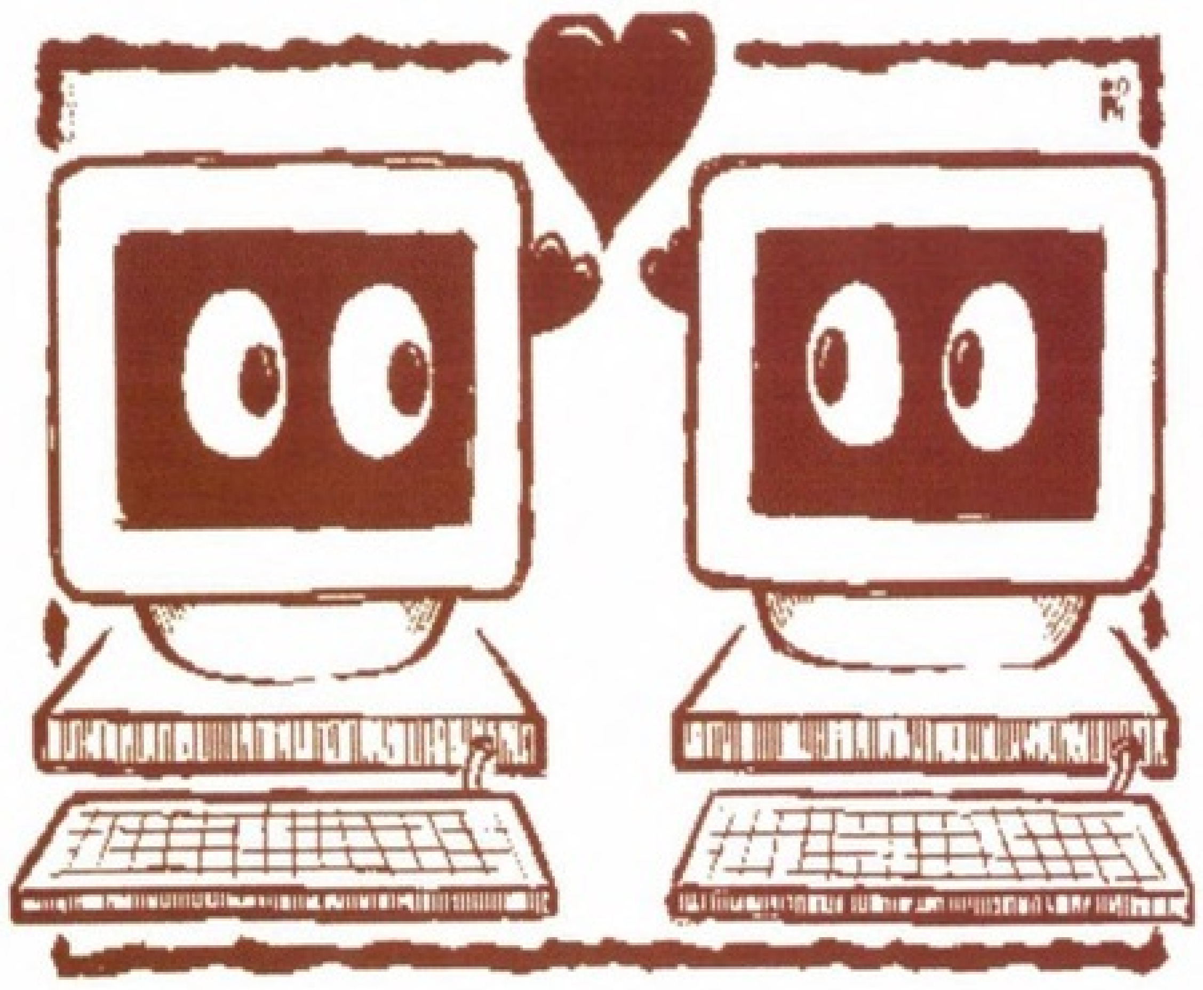
Sterile debate

IN SOUTH-EASTERN Brazil, São Leopoldo's municipal government has approved sterilization as a means of birth control for low-income families with at least two children. The municipal council voted that both tubal ligations and vasectomies be funded by the city government. However, Brazilian law still calls sterilization a form of physical mutilation which is punishable by eight years in prison. Consequently, only three of São Leopoldo's health-service doctors will perform the operations. According to news magazine *Veja*, sterilization is one of the most popular operations in Brazil and doctors do not want to legalize it because they can charge much more for an illegal procedure.

World Press Review, vol 42, no 7

Same-sex partners

A major survey has revealed that almost 25 per cent of multinationals 'are now prepared to recognize same-sex partners' when recruiting men and women for jobs in Europe. Covering nearly 200 companies active in 14 countries, Mobil Europe's data-sharing study reveals a radical shift in corporate attitudes.



Nicola Cole, Gemini News Service

Too much

In response to growing inequality within the US the New York-based Council on International Affairs and the Boston-based Share the Wealth Project are launching a new periodical simply entitled *Too Much*. The first issue looks at what baseball might be like in an America with less inequality. 'Believe me,' says Chuck Collins, the group's co-ordinator, 'it would be a much better game'. Recent studies have shown that the most affluent one per cent of Americans owns 40 per cent of the nation's wealth – more than is owned by the bottom 90 per cent of the population.

Share the Wealth, 37 Temple Place, 3rd Floor,
Boston, MA. 02111

Online radicals

Two useful new 'sites' are available online. The Natural History Book Service (NHBS) offers free and easy access to a catalogue of over 40,000 books, CD-ROM's, videos, reports and papers on the environment: *http://www.nhbs.co.uk*. Corporate Critic Online from the Ethical Consumer Research Association offers a database of information and criticisms of companies under 13 social and environmental criteria. A subscription fee is payable for this service: contact ECRA Publishing Ltd, 16 Nicholas Street, Manchester M1 4EJ, UK.

Energy jam

Blackcurrants could be a valuable source of energy – not in foods, but in power stations. A Swedish agriculturist reckons the bushes could be a good energy source. They grow extraordinarily well in the cold and new, high-yielding varieties have doubled wood production. Blackcurrant power may be one solution to the energy jam.

Consumer Currents, no 175

RWANDA

Double trouble

Exiles escape charges as prisoners die

One year after the genocide in Rwanda there is still no justice for the victims and their families, says a report by Médecins sans Frontières.* Since April 1994, only three people – two in Canada and one in Belgium – have been subject to judicial proceedings.

The vast majority of the military and militias responsible for the genocide have found refuge in Tanzania or Zaire, where they benefit from aid provided by the international community in the form of relief programmes for Rwandan refugees. The French Army, which controlled the south-west of Rwanda in mid-June 1994, took no measures to arrest them.

Meanwhile, inside Rwanda, one in eight of the inmates of Gitarama prison died between September 1994 and May. The prison was built for 400 but there are now over 7,000 prisoners awaiting judgement, the majority of them on charges of genocide. They have less than half a square metre of living space each. Many have no choice but to stand day and night.

Among the referrals to Kasbgayi hospital, 38 per cent are suffering from trauma wounds and 41 per cent from rotting feet caused by standing on the wet and dirty ground, often resulting in amputation. The surgical unit is so crowded that prisoners now have to share beds.

Kasbgayi medical co-ordinator Dr Arnaud Viesse says: 'The conditions in the prison are so bad that we are seeing an increase in serious wounds and burst eardrums from beatings. If an epidemic breaks out there is no saying how many will die – too many are dying already. Gitarama prisoners must be transferred to new centres as soon as possible.'

As many as 47,000 people are locked up in prisons and detention centres throughout the country. The Rwandan Government has announced that seven more detention centres will be opened over the next few weeks, and is building an extension at Gitarama. It is vital that the extension is used to ease the overcrowding and not filled with new detainees. ■

Nikki van der Gaag

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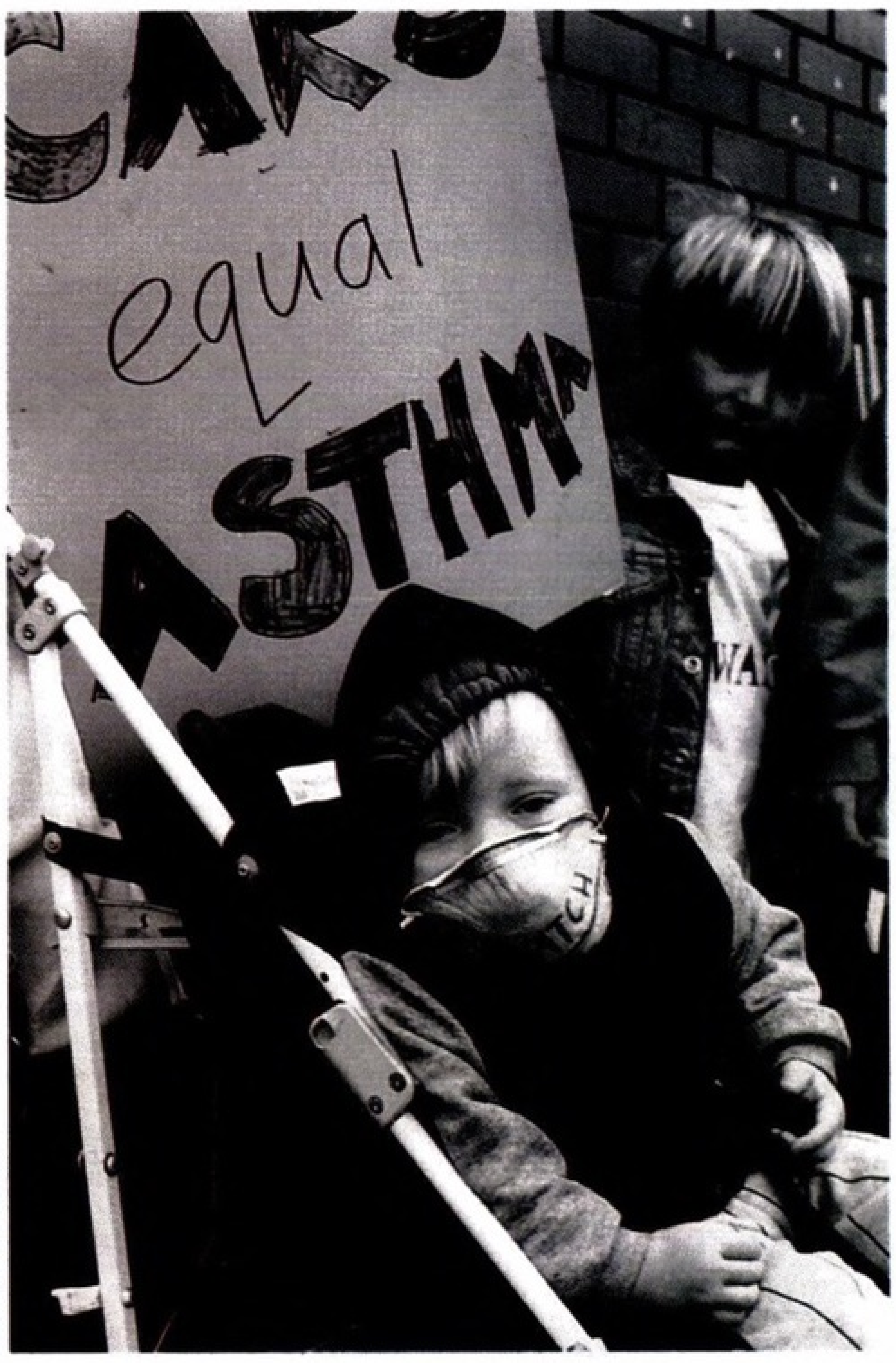
* *Health status of the inmates of Gitarama Prison, July 1995.*



ELAINE KENNEDY

Cars equal Asthma

High levels of pollution bring AIRWATCH demonstrators onto the streets of Islington, London. Islington has the highest level of asthma in the UK, according to statistics collected by Islington 2000, a local environmental group. This kind of local action against air pollution is burgeoning all over the world.

NICARAGUA

Riches to rags

Miskitu people impoverished despite aid

‘THE ATLANTIC COAST is like a millionaire begging for alms,’ says Mateo Collins, one of the leading intellectuals among Nicaragua’s Miskitu minority and former co-director of the Inter-Church Centre for Theological and Social Studies (CIEETS). The region is one of the richest in the world for natural resources – especially minerals, lumber and fish. ‘But we are poor,’ says Collins, ‘and we depend on development organizations even for food’.

Since 1990 the region has received large quantities of aid from the European Union, US AID, UNHCR and the Organization of American States. As one UNHCR official stated sardonically before the organization pulled out: ‘I have had more money in my office here than the Nicaraguan Government has in its Treasury.’

And yet, according to a recent study by CIEETS, 85 per cent of Nicaragua’s ethnic-minority population live in ‘extreme poverty without access to what is necessary for survival’. Around 95 per cent have to drink contaminated water. Malnutrition is common. According to the Nicaraguan Minister for Health, Ernesto Salmeron, as many as 60 per cent suffer from tuberculosis. Unemployment stands at 85 per cent and only 14 per cent of the population have access to secondary school.

Why has the injection of funds made no difference? One reason is that the cost of living is 300 per cent higher here than on Nicaragua’s Pacific coast – nearly everything has to be imported. Local fish stocks are rich but they have provided a fiesta for illegal Honduran and Colombian fishing pirates, taking advantage of the unpatrolled waters of the Atlantic Coast. Some estimates suggest that they are removing two million dollars’ worth of ‘red gold’ (lobster and shrimp) annually. In 1993 foreign industrial fishing took 63 per cent of the shrimp catch.

Although the region is inaccessible it is not so isolated as to escape exploitation by transnational corporations. The once-lush rainforest has been extensively logged. Gold mines were sold last year for five million dollars to the Hunt Exploration and Mining Company and further concessions have been offered by the Government during the past two years.

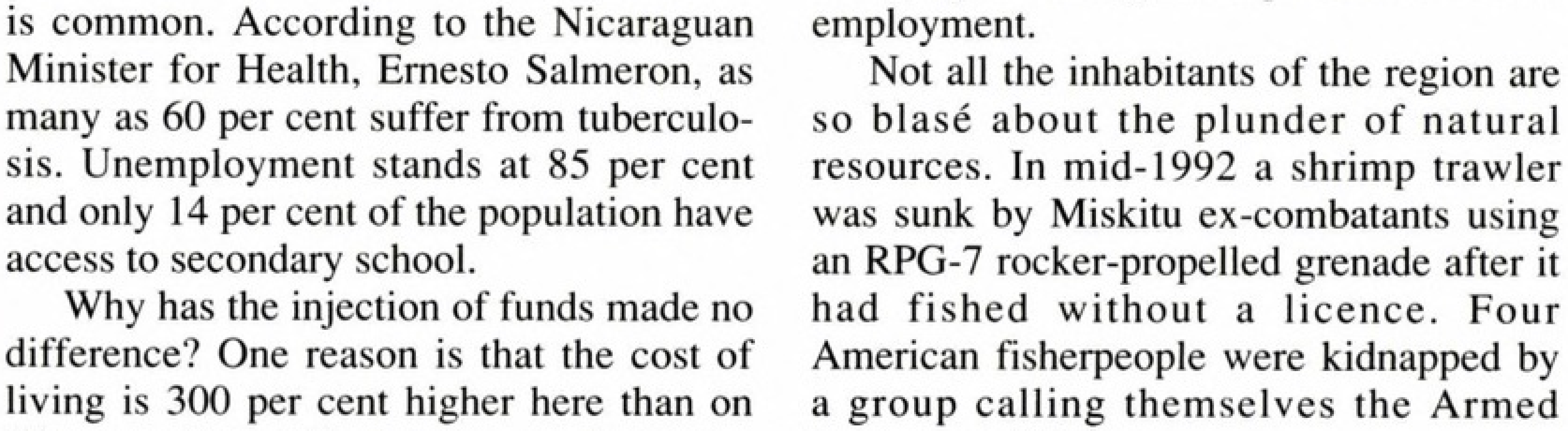
Many of the 70,000 Miskitu Indians, who make up the largest group on the eastern seaboard of Nicaragua, fought on the side of the US-backed Contras during the war. Some of them feel that they could gain a larger slice of the resource pie by developing some form of indigenous capitalism. Armstrong Wiggins, a Miskitu leader who works at the Indian Law Resource Center in Washington DC, sees one of his tasks as ‘facilitating the process by which indigenous people can have private property if they want it’. Steadman Fagoth, another Miskitu leader, advocates bringing in foreign companies to create employment.

Not all the inhabitants of the region are so blasé about the plunder of natural resources. In mid-1992 a shrimp trawler was sunk by Miskitu ex-combatants using an RPG-7 rocker-propelled grenade after it had fished without a licence. Four American fisherpeople were kidnapped by a group calling themselves the Armed Indigenous Militias.

Many Miskitu are disillusioned with their leaders, believing that they are only interested in their own political positions – and pockets. In the meantime, there seems to be no end to the poverty. ■

Susan Hawley

Chlorophyll by Sacha


AND THE WINNER OF OUR 'MOST ENVIRONMENTALLY FRIENDLY PERSON' AWARD IS... CHLOROPHYLL!
BE GREEN, NOT MEAN!
CLAP!
CLAP!
CLAP!
CLAP!
HUH... WHERE'S MY AWARD?..
BEING RECYCLED OF COURSE!
NOW THAT... I SHOULD HAVE SEEN COMING!
CLAP!
CLAP!
SACHA

The Development Set

Excuse me, friends, I must catch my jet –
I’m off to join the Development Set;
My bags are packed, and I’ve had all my shots,
I have travellers’ cheques and pills for the trots.

The Development Set is bright and noble,
Our thoughts are deep and our vision global;
Although we move with the better classes,
Our thoughts are always with the masses.

In Sheraton hotels in scattered nations,
We damn multinational corporations;
Injustice seems so easy to protest,
In such seething hotbeds of social rest.

We discuss malnutrition over steaks
And plan hunger talks during coffee breaks.
Whether Asian floods or African drought,
We face each issue with an open mouth.

We bring in consultants whose circumlocution
Raises difficulties for every solution –
Thus guaranteeing continued good eating
By showing the need for another meeting.

The language of the Development Set,
Stretches the English alphabet;
We use swell words like ‘epigenetic’
‘Micro’, ‘Macro’ and ‘logarithmetic’.

Development Set homes are extremely chic,
Full of carvings, curios and draped with batik.
Eye-level photographs subtly assure
That your host is at home with the rich and the poor.

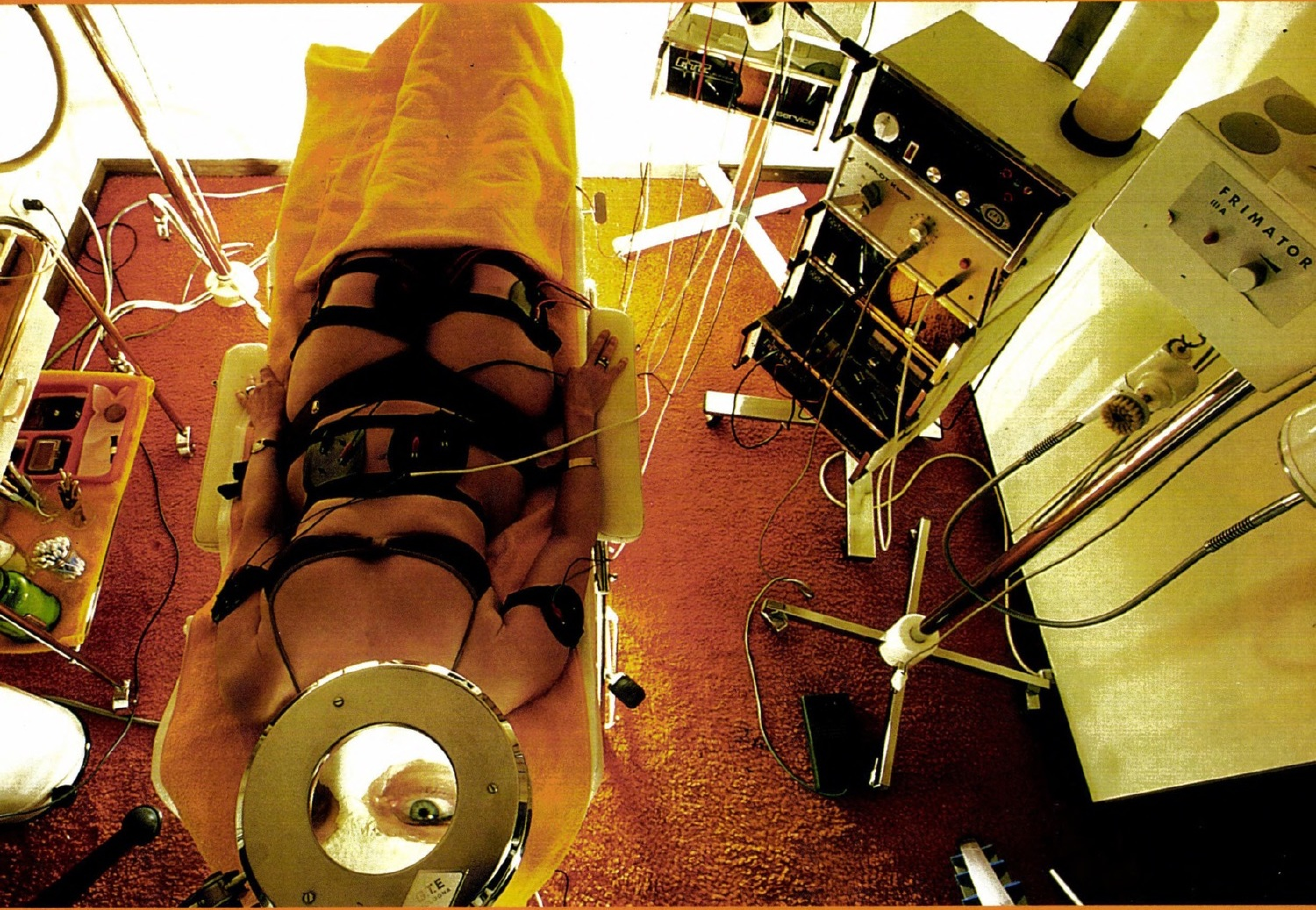
Enough of these verses – on with the mission!
Our task is as broad as the human condition!
Just pray to God the biblical promise is true:
The poor ye shall always have with you.

Ross Coggins

“Quote”

I DON’T CARE HOW MUCH of a Lama he is, he still needs his mother. The monks are spoiling him rotten and he is turning into a little tyrant rather than a little Buddha.

Maria Torres on her son **Osel**, whom Tibetan monks believe is a reincarnation of the Lama.



A VENZAGO / MAGNUM

Medicine

Cure or curse

Medicine can be bad for your health. **Dinyar Godrej** investigates the perils of treatment and the meaning of healing.

A PROUD WOMAN, our friend lost all her hair. So she wore a bright orange headcloth with 'gypsy' earrings. Puffing on a forbidden cigarette, she'd fix you with her penetrating eyes, even more magnetic now that her eyebrows were gone, and ask: 'And how are *you*, my darling?'

Our enquiries about 'the treatment' would be met with a look of intense, almost theatrical pain. 'Ah, you don't want to know about that,' she'd say sharply, then ask: 'So what's the gossip?'

She didn't believe the treatment was any good and her family, friends and doctors knew it was next to worthless. However, it meant her incarceration in hospital. The regimes of chemotherapy and radiation – in some cases therapies in name only – often bleached out the

An alternative Ahh! Acupuncture with burning herbs in Taiwan (above). Conveyor belt riches: prescription drugs at Merrill's Cincinnati plant (bottom right).

IAN BERRY / MAGNUM

person we loved. So I'd find myself inwardly applauding her when told she'd been caught yet again, strolling the streets in hospital gown and handbag, doing a bit of shopping.

Time was when the inevitability of illness and death commanded other kinds of ritual, the gathering together of kin, the uttering of a few well-chosen words. Death happened in the familiar surroundings of one's home. Now it's medicalized, socially acceptable only when every desperate remedy fails. 'Life' can become a drug- and machine-fed limbo which ends with the click of a switch.

A large part of modern medicine's brief seems to be about cheating death, devising more and more tortuous ways to stay alive. Medicine intervenes in our lives and deaths, in our pain and sickness, taking control, promising us health which becomes ever more elusive as treatment slips from our hands.[1]

Consider this: most common illness can be cured at home with proper medical advice and by eating well, resting, letting the body's defences do their stuff. Some infectious diseases need a doctor's attention, while others can be prevented by vaccines. Beyond this, doctors are of limited use. Apart from the obvious, life-changing benefits of operations like cataract removals and hip replacements, the vast majority of surgical interventions are 'unproven in their effectiveness and may actually do more harm than good.'[2] Some prolong life while greatly diminishing its quality. As for chronic conditions related to the ageing of our bodies, doctors disguise the fact that they can do little by doing too much, prescribing pills and treatments with their attendant side-effects. In Australia a recent study based on 14,179 hospital patients found that the third-largest killer after heart disease and cancer was mistakes made by doctors and nurses.[3]

Why doctors persist in useless regimes – the repressive associations of the word are apt – is a good question. Cynics like George Bernard Shaw believed that a doctor was 'the grossest of impostors' whose 'abject [financial] dependence on his [sic] patient forces him to flatter every fashionable fad and practise every fashionable quackery'.[4] But it is also the magician status we ascribe to the white coat that makes the doctor's position one that has to be bolstered with banks of pills and paraphernalia.

Drug abuse

At present doctors prescribe far too many medicines, and we as consumers purchase too many off our own bat. This is increasingly true of many parts of the Majority World that are otherwise starved of healthcare provision. The roots of this drug abuse in Western medicine lie in the profession of the apothecary, who could not legally charge patients for health advice, only for pills and potions. But it was the advent of 'miracle drugs' – antibiotics – from 1930 to 1950 that led to the marriage between doctors and the drug industry and thence to the widespread susceptibility of the general population to pill-popping. Incurable, deadly diseases like tuberculosis, meningitis and syphilis could suddenly be blasted by drugs and a complete cure effected. This was a tremendous boost to all drug taking, not just antibiotics.

In the decades that followed we have been blasting away, indulging in a kind of germ warfare that has taken on heroic proportions. Here's an interested party's view of it: 'Our industry produces the enchanted substances that give healthcare professionals their real power to cure. Prior to the Second World War there really weren't too many things that would help. Doctors could tell you to keep in bed, keep warm, drink a lot of fluids, and they can make you feel better. But because of the investments in research and development that our companies have made, we really are making many diseases obsolete.'[5]

Don't you believe it. Antibiotics kill bacteria. They may be targeted against harmful forms, but they also create havoc among all the friendly bacteria that live on us – one million per square inch of skin. Friendly bacteria actually keep dangerous forms at bay. So when an antibiotic treatment knocks them out with a bit of friendly fire, our resistance to other infections is weakened.

Bacteria are single-celled creatures with great genetic adaptability. Antibiotic-resistant forms are now on the increase and the old medicines are not working. Even friendly bacteria have mutated into life-threatening forms. People are dying before doctors can identify the correct antibiotic. Antibiotics are in their third and fourth generation, increasingly expensive and, with the world set to use 50,000 tons of them by the year 2000, the drug companies are laughing all the way to the bank. Drug company profit margins have been compared by one critic to those of cocaine dealers.[6]

Antibiotics could still be effective if used sparingly and accurately, but this is often not the case. Doctors in one London hospital were found to be treating patients without first identifying the bug. Four out of five cases of tonsillitis are caused by viruses, not bacteria, yet doctors usually prescribe antibiotics which do nothing to viruses. They have no way of telling virus from bacteria by peering down your throat. I have an attack about once a year and my otherwise restrained GP normally prescribes penicillin.

The drug companies encourage this kind of thing. One drug on the Pakistani market is advertised as 'Curitol to Cure it all'. By reading the promotional literature one would think that every possible ailment would cower before its attack. Tucked away on another page in microscopic print are its side-effects – affecting most parts of the body one would care to name.

Drugs are toxic substances. A packet of pills I bought over the counter for my hayfever could have affected my heart rhythm. Some can cure, others will kill. Encouraging greater drug use lessens effectiveness and increases the potential for things to go horribly wrong. Drugs are usually researched and made by big businesses, not by practising doctors. These businesses give gifts to doctors, sponsor their conferences, donate money to hospitals. They keep medical journals alive with their advertisements. They spend more on marketing than on research. They are not interested in cures, but in lengthy, expensive treatments. Imagine the loss to the industry if a drug could actually *cure* heart disease or arthritis.

Holistic promise

'Research' involves not just guinea pigs but monkeys, cats, dogs, rats, mice, sheep, rabbits. Hundreds of thousands of animals are killed each year in the name of putting 'safe' drugs on the market. In reality if experiments support the drug then they are cited as evidence; if there are contraindications then it is claimed that the physiology of the animals is too different to make an adequate comparison. What is needed is not more animal trials of dubious value, but more human trials.[6]

ANDY SNOW / KATZ

The word 'science' justifies anything. It is certainly used to bait alternative therapies, many of which have been around a lot longer than allopathic ('Western') medicine. The Western scientific approach is a single, closed system of rules which pooh-poohs other discrete systems and claims to be the only acceptable, universal approach. It has narrowed our conceptions of health and disease to biology, separating the individual from the wider environment. It takes up practices like acupuncture and some homeopathic remedies without buying into the holistic philosophies from which they spring.

The holistic promise has great appeal in an increasingly fractured world. Alternative therapies claim to look at the entire person, our physical-mental-spiritual condition, before making a diagnosis. They may be gentler than allopathic medicine but because they haven't been taken seriously the scope for uncritical worship and unjustifiable treatment is tremendous. One AIDS 'cure' marketed as Ayurvedic medicine turned out to contain a significant amount of dung – a literal case of treating the patient like shit. Homeopathy worked wonders for my father's piles and my mother's thyroid problems, but did nothing for my myopia.

Beneath the holistic idea lies the premise that we can control our own health. It is a short step from here to blaming a person for their ill health.[7] Such is also the 'healthism' of conventional medicine. Under the guise of health promotion comes a long list of taboo activities to be avoided for one's own good. They are of little comfort to people with diabetes or epilepsy. For others they are a magic formula masking our desire to live forever. Sometimes I wonder if the extra years I might gain by jogging for half an hour each day is equivalent to the time I'd have spent on the exercise. My better health would doubtless add a glow to the quality of my life, but I refuse to perform any exercise that bores me (dancing another matter). I reckon that being able to choose the lifestyle I lead is more beneficial to my health in its entirety.

Healthism often divorces individuals from their environment, from which most ill health directly or indirectly arrives. Along the faultlines in our world we can see the ills that attend them. Take gender. In India 330,000 more girls than boys aged under five die each year. Women aged over 15 consistently have higher death rates from major diseases than men. The genetic advantage that women have over men (living longer) has been wiped out in India by social disadvantage. Around the world women get prescribed tranquillizers and anti-depressants for their ailments by doctors who either feel powerless to change the domestic problems these arise from, or who just don't care. In Peru women's frustration and anger are made into an illness ('*nervios*') which can sometimes give them the right to leave their homes and act more independently. Research in the US found that women who had been raped were nine times more likely to attempt suicide than other women.

> *Under the guise of health promotion comes a long list of taboo activities to be avoided for one's own good*

Medical research disadvantages women as well. Two major US studies on contributory factors in heart disease used huge samples of men and no women. Either the researchers were under the mistaken assumption that women's bodies were the same as men's, or they couldn't be bothered with the difference.[8]

When it comes to doctoring for women, their fertility and its control continues to be an obsession. Most contraceptives for women are invasive and risky. Women undergo far more sterilizations than men, even though the possibilities of complications are far greater.

The schism of race also influences the kind of treatment available and the degree of ill health. But by far the most important divide is money. The World Health Organization has woken up to the fact that poverty is the world's number-one disease. Overcrowding, lack of sanitation and hunger contribute more to ill health than any trendy virus or scare and no amount of medicine will put that right. Homeless New Yorkers die of tuberculosis for the same reasons as millions in the Majority World – their resistance is low due to the conditions they live in. The downward trend in TB in the West began before antibiotic use, as a direct result of improved living conditions and hygiene. Now that squalor is returning, so is that scourge.

Bereft of basics

For the Majority World grandiose schemes for *Health for All by the Year 2000* were agreed in 1981. They resulted in aid action that looked good – immunization, the building of latrines and the like. Numbers became terribly important: the numbers of 'lives saved' or outhouses constructed.

Emotions ran high. 'Child survival' became the buzzword for the US Congress, which gave generously to programmes promising this at the expense of less dramatic, unquantifiable ventures which attempted sustainability and local management.

The majority of the world still lacks decent, basic healthcare. The rich world indulges in increasingly sophisticated and mostly useless medicine. Can there be any vision of medicine that will bridge the two? Perhaps we need to reconsider what we mean by medicine. Should it mean pills and surgery? Or should it mean something more: basic rights for all, respect for the environment, an end to conflict? My disquiet about the ills of medical treatment may be a metaphor for the larger ills that thwart our happiness, the ills of greed, waste and want.

One thing is of the utmost importance – care. Many a patient who has been cured by an uncaring, brusque doctor lives with resentment at such treatment. The famed 'bedside manner' of doctors is often a casualty of increased management by business-school graduates. As a child I used sometimes to wish I would fall ill, because of the thorough pampering I would get from my family. Their care nursed me through bouts of malaria, jaundice, chicken pox, conjunctivitis, through surgery and mental turmoil. Within this aura of concern a healing took place that was deeper than biology.

Care is still a stranger to our plans for better health and better medicine. It needs to be invited in, before the priorities can ever be made right, before we can wrest healthcare from bureaucrats and big business, and think beyond individual health to the health of communities. With care also comes a sense of direction about our own mortality, other than merely wishing to stave it off. Think what the doctors at their conferences, the planners at theirs – and you and I going about our business – could achieve if we bore in mind this ancient exhortation of Pindar:

Dear soul, do not strive for immortal life, but exhaust the resources of the feasible.

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1 See Ivan Illich, *Limits to Medicine: Medical Nemesis: The Expropriation of Health,* (Penguin Books, Harmondsworth, 1976 and 1985), for an early discussion of these ideas. **2** David J Hunter, 'From tribalism to corporatism: The managerial challenge to medical dominance', in *Challenging Medicine*, eds Jonathan Gabe et al (Routledge, London and New York, 1994). **3** *New Scientist*, 10 June 1995. **4** Quoted in Petr Skrabanek's *The Death of Humane Medicine and the Rise of Coercive Healthism* (The Social Affairs Unit, Bury St Edmonds, 1994). **5** Gerald Mossinghoff, President, US Pharmaceutical Manufacturers Association, 1989, quoted in Geoffrey Cannon's *Superbug* (Virgin, London, 1995). Information on bacteria and antibiotics mainly from this source. **6** Vernon Coleman, *Betrayal of Trust*, European Medical Journal (Lynmouth, 1994). **7** Rosalind Coward, 'The myth of alternative health' in *Health & Wellbeing*, eds Alan Beattie et al (Macmillan & the Open University, London, 1993). **8** Facts on women from Lesley Doyal, *What Makes Women Sick* (Macmillan, London, 1995), and *The Health of Women*, eds Marge Koblinsky et al, (Westview Press, Boulder and Oxford, 1993).

Peddle power

Zafar Mirza witnesses the benefits of antibiotics being squandered in Pakistan

THE DRUG-USE SITUATION IN PAKISTAN is alarming. Anybody can step into a medical store and buy any drug. Usually a prescription is neither demanded nor shown. Antibiotics are no exception. People take them for trivial symptoms like headaches and other aches and pains. Among lay persons there is hardly any concept of infection or a course therapy. If a headache is 'treated' with one tablet of erythromycin, that is fine!

This liberal approach towards antibiotics is just as prevalent amongst medical practitioners. A typical prescription by a private general practitioner contains one or more antibiotic preparations, a painkiller/antipyretic (for lowering fever), a sedative and a vitamin or tonic preparation. One of these medicines is invariably injectable, which is the most risky way of taking medication. You are lucky if a steroid isn't added to this list or if you don't get more than one drug of the same category. Prescriptions of six to eight drugs are not uncommon.

The public sector spends 80-90 per cent of its drug budget on about 10 per cent of the population mostly in healthcare facilities in cities. Rural healthcare is fraught with a chronic shortage of medicines. Physicians prescribe whatever is available, with no special consideration for antibiotics. There are huge numbers of unqualified practitioners. Almost all of them, regardless of their type and school of thought, freely prescribe modern medicines, including antibiotics.

Antibiotics are, as a result, fast losing their potency and efficacy. Simple infections are becoming increasingly difficult to treat with first-line antibiotics. Alexander Fleming, after producing the 'miracle' drug penicillin in the first decade of this century, warned the medical world that 'the greatest possibility of the evil in self-medication is the use of too-small doses so that instead of clearing up infection, the microbes are educated to resist penicillin, and a host of penicillin-fast organisms is bred out which can be passed to other individuals, and from them to others, until they reach someone who gets septicaemia or a pneumonia which penicillin cannot save'. He predicted a phenomenon we are witnessing today.

A survey of four hospitals by the National Institute of Health in Islamabad in 1991 revealed that Streptococcus Pneumonia and Hemophilus Influenza were 70-per-cent resistant to Septran and 40-per-cent resistant to Ampicillin. Both these drugs are considered the drugs of choice in the treatment of respiratory infections. In Pakistan, acute respiratory infections are the biggest cause of morbidity and mortality in children under five years of age. Every year approximately 250,000 die due to pneumonia. Having blunted their primary weapons, the prescribers are now resorting to second- and third-line antibiotics – inappropriately as well.

CHRIS STOWERS / PANOS PICTURES

False model: almost anything goes in Pakistani pharmacies.

Penicillin resistance to gonorrhoea has emerged and there has been widespread resistance to shigella, with epidemics of resistant strains in Bangladesh and Nepal. Liberal and inappropriate use of anti-tuberculosis drugs on the Afghan-Pakistan border has produced bacilli which are multiple-resistant.

Pharmaceutical companies are busy making big money out of this therapeutic tragedy. Instead of promoting the correct use of first-line antibiotics, they look at the emergence of resistance to these antibiotics as an opportunity to push third-line antibiotics, as these are more expensive and make more money. Manufacturers enjoy patent protection for most of the new antibiotics, whereas almost all the first-line antibiotics are no longer protected.

In 'developing' countries, because of lax regulations, the industry has almost a free hand for promotion of its products. By enticing the prescribers and sponsoring their conferences they develop a symbiosis which ultimately works against the interests of the patients. Unethical promotion by pharmaceutical manufacturers has been the hallmark of their marketing strategies.

In Lahore recently Upjohn, a multinational drug company, was found to be offering a direct monetary incentive for prescribing one of their antibiotics, Lincocin. The *modus operandi* was simple; write down 500 to 1,000 prescriptions for this drug, keep copies as proof, hand them over to the visiting company rep and you will be compensated for each prescription at a fixed rate. A few conscientious professionals objected and the company had to roll back the scheme. Lincosin's generic name is Lincomycin which, according to the WHO, is a non-essential antibiotic not even included in the National Essential Drug List and is not considered safe compared to the alternatives.

The single most important therapeutic discovery this century – the antibiotic – is losing its power. It is time to act. ■

Dr Zafar Mirza is National Co-ordinator for The Network for Rational Use of Medication in Pakistan, based in Islamabad.

JEFF SPEED

Bandaid and therapy

Toronto family doctor **Debbie Honickman** chronicles a day in the life of a healthcare system that's in need of a fresh diagnosis.

8.30am ON MY WAY to work I cycle past a crowd of protesters outside the College of Physicians and Surgeons. They're carrying placards supporting a doctor who practises environmental medicine. He's been accused of using 'unproven' methods by the College's Discipline Committee.

Some of the placards speak about pollution, claiming the doctor helps to treat its effects. I muse over an irony. People can be motivated to take action in defence of someone who can protect them from the effects of industrialism. But have any of them driven their cars to the protest? And would they be willing to carry their placards outside polluting workplaces? Perhaps I'm being overly cynical but I wonder if it's mainly self-interest that's politicizing these protesters, while the root causes of environmental diseases go unchallenged. I go on an internal tirade over issues of prevention and advocacy, and arrive at work determined to incorporate protection of the environment into my everyday practice.

9.30am IT'S AN ODD coincidence: my first patient may have an environmentally induced problem. He complains that his asthma has gotten worse in the last few weeks. I have to sort out whether this is because it's allergy season; because the CO_2 emissions are worse lately; or because he's sick from his work. P has come recently from South America and is working in Canada illegally. He's being paid far below union wages in a factory with disgusting air quality.

I realize that if I report his employer he'll lose his job – whether or not the factory is shut down. I can't file a worker's compensation claim for him as he doesn't have landed-immigrant status yet. I could tell him that this city is making him sick and advise him to move to the country – where the unemployment rate is even higher and he will face more blatant racism. We could discuss the fact that the Earth and his work environment need to be healed.

Instead, I explain his so-called options and the possible causes for the aggravation of his breathing. Then I write a prescription

Inner-city blues: lost on the streets (above) or in a Parkdale bar (previous page), it will take more than pills to cure what ails these Toronto citizens. Humour therapy: Debbie Honickman outside her clinic (opposite bottom).

JEFF SPEED

for inhaled steroids (warning him that these may cause thrush which would then have to be treated with further medication) and I feel like shit. He decides he'll marry a Canadian with a place in the country and wonders if I am available. Some might say I'm being harassed by my patient. I decide to laugh. He has enough worries. And after all, who has the real power in the relationship?

My next patient is a 20-year-old woman from the Caribbean who is also here illegally. Her boyfriend is sponsoring her. S has had two clinical abortions. Recently I treated her for a sexually transmitted disease with metronidazole, which is known to cause foetal abnormalities in rats. At the time I advised her not to take the medication until she got her period, because while the infection wouldn't be harmful to a foetus, the drug potentially was. She took the medication. She got pregnant. She decided to have another abortion because of the risks and because her partner was abusing her physically.

> *I'm struck by the fact that she needs another person with 'power' to deal with a person who made her feel powerless*

Today she tells me that he found out. He beat her up and told her he would have her deported if she didn't go through with the pregnancy. She tells me she'll keep the baby. She and our outreach nurse call MotherRisk, a programme affiliated with our city's paediatric hospital. MotherRisk's view is different from mine. They inform her that the foetus is not at risk from the medication. I fret for several minutes, still having my doubts and fears. I call MotherRisk again to confirm that she really isn't endangered. This is the easy part of the problem. Her 'boyfriend' is abusing her physically and sexually in exchange for not reporting her to immigration. I feel very helpless and unsure how I can be of help. Sponsor her, share my income, raise her child, get rid of her boyfriend?!

Before my 11.00am appointment I return two phone calls. If I were in private practice I would probably be feeling anxious, as I wouldn't be receiving payment for time on the phone. The first caller is an Ojibway woman who had been my patient when I was working for a First Nations-run community health centre. She is asking for a referral to a renowned Canadian aboriginal healing centre that deals specifically with substance overuse and incest-survival issues. She is upset that her current doctor won't fill out the forms for her referral until he knows her better. She requires to be cleared medically before the treatment centre can accept her application.

She is frustrated by her total dependence on the medical profession to enable her to get what, from her perspective, she knows she needs. I suggest that I call her doctor for her and explain why the forms need to be filled out. I'm struck by the fact that she needs another person with 'power' to deal with a person who made her feel powerless.

The next call I answer results in my being behind with my appointments for the rest of the morning. It's from a man I know from Street Patrol (an evening service that provides food, clothing and comfort for people living on the street). He's calling to tell me that David has died. David was an Anishnawbe man (half of my patients are Anishnawbe) whom I'd known for four years, an ironworker who had lost his job after a fairly serious accident. Though he recovered physically, he never worked again.

When I met him he was living in parks, in alleyways, and was well on his way to cirrhosis of the liver. When David wasn't drinking he was a gentle, sad, thoughtful man. When he was drinking he expressed his rage verbally and could be pretty mean. But I was never afraid of him, even though he did once threaten my colleague with a knife in my office. When I find out he has died behind our local liquor store I feel as if I am somehow responsible. Most of the times he came to our health centre he was so intoxicated it was difficult to assess him. We didn't have the facilities to detoxify him and he would always storm out before we could get him to hospital or a detox. Most of what I could do for him was bandaid.

I feel so horrible this morning, thinking about how I failed to address with him the problems that kept him drinking – racism, homelessness and sexual abuse by his father (who had been sexually abused by his father, who had been sexually abused by the priest in the residential school he was forced to go to). I feel pretty helpless, have a good cry and share my grief with colleagues who also knew David. Then I go to see my next patient. I don't think I have time to think properly about his death and I know this is a reflection of how it has always been for him. Not enough time and not enough resources.

A memorial will take place next week at the drop-in centre where he had been barred several times for rude and dangerous behaviour.

11.30am Last patient of the morning. Someone who almost certainly has one of the hundred-or-so viruses that cause the common cold. I usually start by examining the person to make sure they don't have something unusual – for instance, are they about to asphyxiate from epiglottitis? could it be the 'flesh-eating bacteria'? were they exposed to mouse droppings and are they about to die of Hanta virus? I may take a throat swab if they are (or I am) particularly anxious. Then I explain what they can do next time they have a cold, what environmental factors might be ever so slightly lowering their resistance, and then I do my drug-company spiel. About the TV adverts that are designed to make them think that I'll be able to provide them with medicine to cure them. About the profits that drug companies make from this advertising. About the uselessness of most of these cold remedies. About the simple measures that they can take to feel better. Like not smoking. This is a good time to quit, I explain to this woman. (According to the Canadian Consensus Guidelines for Clinical Medicine, one of the few things doctors do well is to counsel people on how to quit smoking.)

All of my patients are booked for a full half hour, so if someone comes in with a cold that takes only a few minutes to assess it's an opportunity to find out if I can support them in other ways. It's time for education, time for humour therapy (get those endorphins going) and time for... doing all the paperwork I'm behind on. They never taught me in medical school that I would be doing so much paperwork. It makes me think of deforestation. The welfare department should have a hemp plantation.

1.30pm **Missed lunch**

1.45pm **House call.** Sophia, a 75-year-old Portuguese woman married to the same abusive man for 40 years. Alcoholic son still living at home. Daughter married to intravenous-drug-using man. Sophia is grieving the loss of her sister, who died during open-heart surgery. Sophia has unstable angina and is refusing surgery from which she might benefit. Could her refusal be part of a prolonged grief reaction to her sister's death and to her miserable marriage? Maybe her depression could be resolved with drugs. Maybe therapy would be more helpful. Maybe then she'll want open-heart surgery. And maybe then she'll die on the operating table, just like her sister. Obviously I have no easy answers. And unfortunately we haven't really gotten to this stage of analysis together, partly because her English is not proficient enough and she refuses to see a Portuguese-speaking therapist. Her community might find out.

HEALTH
CLINICA MEDIC
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HOURS
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WHY MUST WE
LTH CARE IS

JEANETTE L ANDREWS-BERTHEAU

I resolve to spend more time with her, bringing a translator to address these issues in a meaningful way. I remember that this is not a new resolution for me.

Fortunately I work in a community health centre where I meet with other staff, nurses, doctors and therapists as well as community outreach workers and health-promotion workers. I can take my problem about Sophia to the group.

3.00pm **Paul.** Goes by the nickname of Skinny. Former heavy solvent user. Work with him has focused on harm reduction. He is now finally housed and is only sporadically using. Good use of supports in the community. Needs major dental work. Most of it not covered by his health plan. Gum disease. He can't eat without major pain. Wants canned nutrition but the Ontario Drug Benefits programme has cut that off the list of benefits. Now I have to fill out a special form stating why he needs liquid nutrition, for how long and how many cans a day. These cuts will only get worse with our newly elected Conservative Government.

3.30pm **Lou.** Former IV drug user. Positive for hepatitis C antibodies. Liver tests slightly abnormal. We now have the technology to screen for it. But we also have an expensive new drug to treat it. Funny how the ability to screen for it and the discovery of this new drug happened to coincide. I mention this to Lou as I make the referral to the liver specialist.

4.30pm **My last patient** of the day has become more of a friend than a patient. I'm sure the College of Physicians and Surgeons would counsel me wisely against this. I have known him for five years and he has just been diagnosed as having a malignant tumour. His prognosis for one-year survival is five per cent. He is 40.

He has a very positive attitude about death. Sometimes I feel that I get much more out of his visits than he does. The Ministry of Health should pay him for doctor education. I call our encounters 'supportive therapy' on the diagnostic sheet. I'm not sure who is getting more support.

We go across the street for coffee – part of the therapy. He smokes. I don't advise him to quit. Our hardest problem in the last six months was in trying to arrange his radiation for early in the day so he didn't have to go too long without a cigarette. He is a Cree man from Northern Manitoba and he misses the bush. Can part of my treatment be to take him out there for the day or would that be considered inappropriate? Too bad, I decide – I have Friday off, I ask him if he wants to go. We will take someone from the health centre, to ensure this is not considered sexual harassment by a physician.

5.45pm **End of the day.** Stayed late to do a bit of paperwork, but not much because I generally try to do it between patients. Some people might think that if I'm not seeing 'patients' then I'm not working. I resent this. It means that all the advocacy work I do is, according to them, not work. And yet advocacy often feels like the only effective thing I can do. Use my so-called power to effect change.

Of the women I saw today, 80 per cent had been sexually abused. Is there something about me that attracts sexually abused women? I think not. I believe the statistics are wrong and far more women are incest survivors than most studies reveal.

Of all the people I saw today, 20 per cent were inadequately housed or homeless. I wrote one letter advocating better housing, filled out four welfare forms, wrote one 'sorry, he missed parole today but he was not well' letter (a lie – he had no money to get to his appointment), filled out seven prescriptions and only felt ambivalent about two of them. I grieved over one dead person and one dying person and I encouraged one to quit smoking. One person let me try out my novice acupuncture skills on him and I actually managed to relieve some of his shoulder pain. That's pretty gratifying since most of the day I wonder why I'm being paid as well as I am because it feels as if I never do anything to make people better. Are my listening skills really worth that much?

10.30pm **I've eaten** supper and am now trying to write an article for the **NI**. Trying to discuss several ideas with my partner. I'm becoming incoherent... Word-finding difficulties... Have to stop... ■

Debbie Honickman works at the Niagara Health Centre in Toronto and is a member of the Medical Reform Group.

Deadly ambition

Bacilli and viruses live for fame and stardom. Every young germ aspires to bring down a Liberace or to be chased by Dustin Hoffman on the silver screen.

So pity the poor, ordinary tuberculosis bacillus. This boring bug has been around for millennia. It's been found in ancient Egyptian mummies and in the bones of South Americans who lived in 3000 BC.

Tuberculosis has seen better days. *Mycobacterium tuberculosis* used to be the disease of celebrities, killing off legions of famous poets, writers and musicians. Kafka, Thoreau, Keats, Poe, Orwell, Chekov and Chopin were all afflicted with the disease. It was the AIDS epidemic of our grandparents' generation with an added terror: this incurable disease travelled through the air.

But then, about 35 years ago, scientists discovered an almost perfect cure. If administered properly, this combination of medicines proved to be nearly 100-per-cent effective in obliterating TB bacilli from the lungs. The entire course of treatment – known as 'directly observed treatment, short-course', or DOTS – now costs as little as $13 in some parts of the world. It is considered to be one of the world's most cost-effective public-health interventions.

It seemed that TB's career was over for good.

But don't believe the reviews. The drugs have yet to be put to extensive use throughout the world. Consequently, the TB epidemic never went away and has actually worsened, killing millions each year.

So why are people surprised to learn that TB kills more children, teens and adults than any other infectious disease? Why do they shake their heads in disbelief when they discover that TB kills many times the number of people who die from AIDS each year? Why are they shocked to discover that a third of the world's population – nearly two billion people – are infected with the TB bacillus? Why has this terrible germ still not been featured in a Benetton ad?

To answer these questions, we decided to ask the TB bacilli themselves. Through new –and otherwise useless – technology funded by a $2.5 billion grant from the National Institute of Health, it is now possible to communicate with TB bacilli.

TB BACILLI AGREE TO TALK TO JOHANNES CHLAMYDIA ON THE EVE OF THEIR WORLD TOUR

NI: We are surprised to find you here. Everyone told us that you had gone away.

Doug the Bug: That's a big myth. Every year we and our friends kill nearly three million humans. In the past decade we've caused over 80 million people to be sick, cough up blood and suffer with fever. We've been hard at work, but nobody pays any attention to our tragic performances.

Sherm the Germ: Yeh, our old friends, The Plague, travelled to India and killed 54 people last year. They caused pandemonium and mass evacuation.

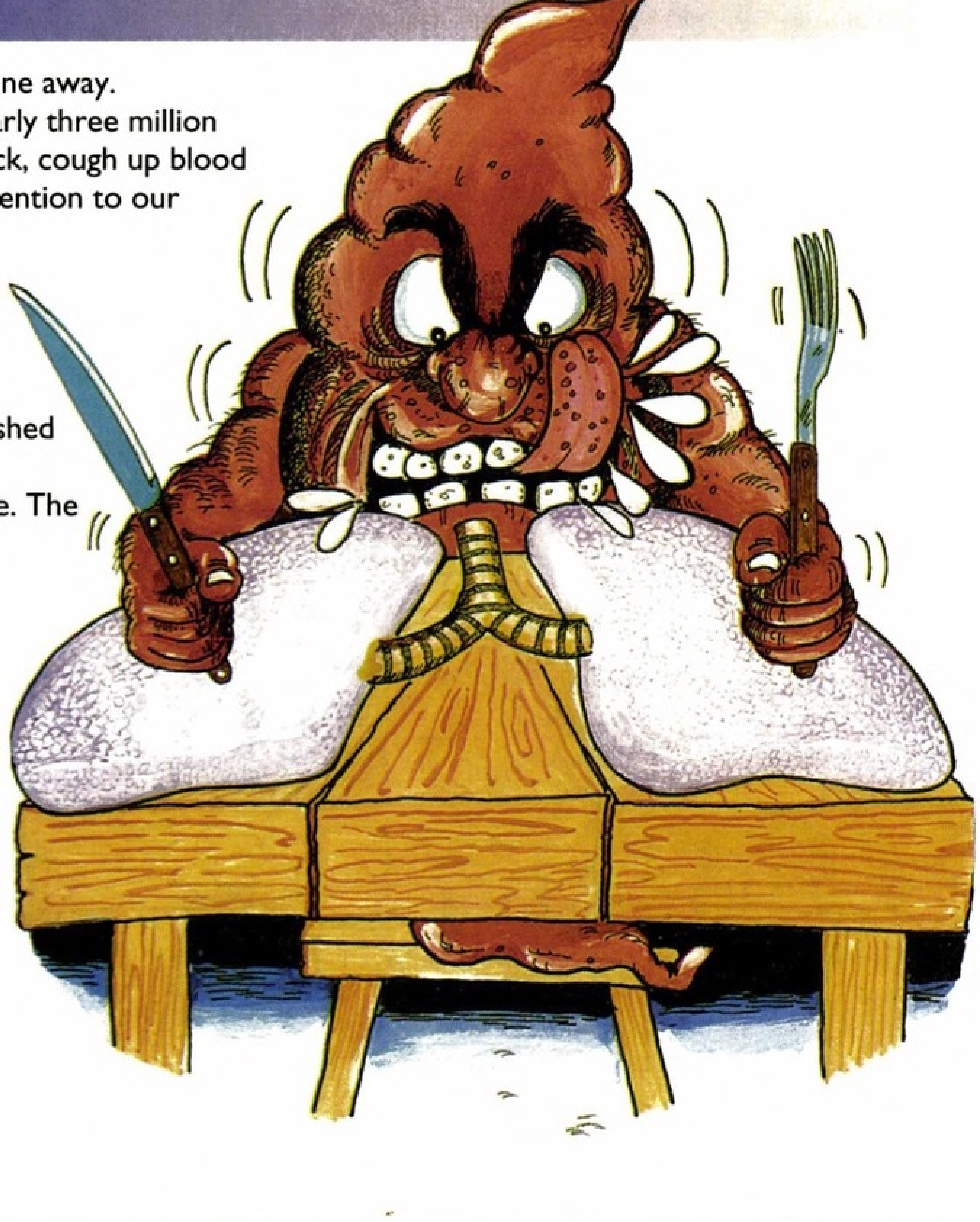
Doug the Bug: The Ebolas visited Zaire and were an instant front-page success. During the time it took them to kill just 200 people we extinguished a quarter of a million lives. But nobody noticed us.

Phyllis the Bacillus: That's because Ebola bleeds them from the outside. The camera crews love it. We only bleed them to death from the inside.

NI: So fame continues to elude you?

Kim the Mycobacterium: We think we have figured out why our careers have hit hard times. Nine out of ten of us live in economically developing countries. Life is easy there and nobody hassles us. Many of those countries haven't invested in the effective and ridiculously cheap TB-control systems that can make our lives miserable. China, Tanzania, Vietnam and Nicaragua are among the few exceptions. I pity the poor bugs still trying to live there.

Doug the Bug: So the problem is, although we're causing lots of suffering, nobody pays any attention to our horrendous accomplishments in the South. No media coverage, no charity auctions and no protest marches. Nothing! It's as if we don't exist.



Phyllis the Bacillus: We decided we'd have to work harder to recapture the spotlight. We're doing a lot more travelling and trying to get booked in more cosmopolitan locations. The world is smaller now and it's easier to get around.

NI: What are your travel plans?

Phyllis the Bacillus: Romania for me. The deterioration of Eastern Europe's healthcare systems following the collapse of socialism is an open invitation to make a prolonged visit. Then it's on to Germany.

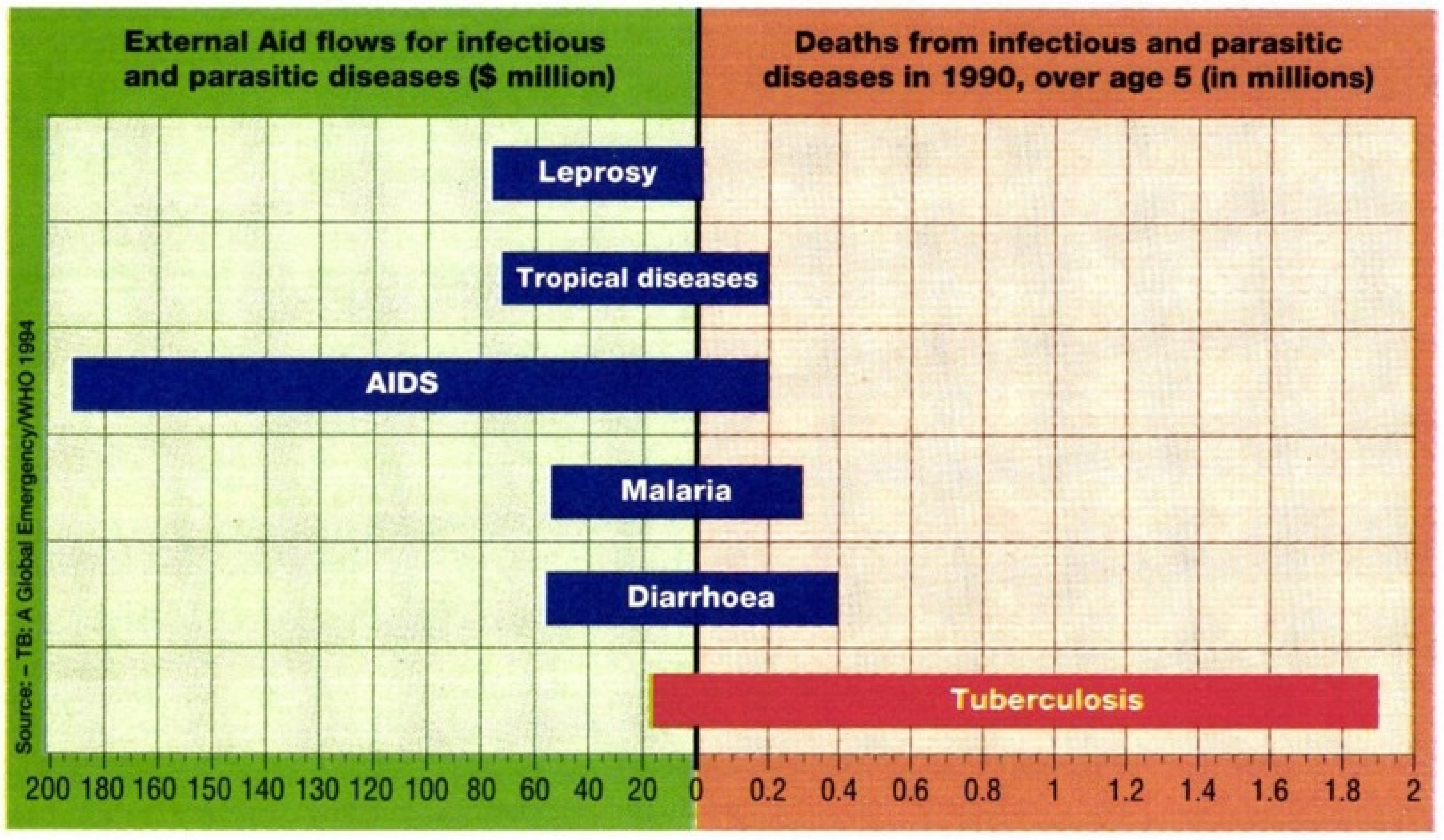
Sherm the Germ: I've been in England recently. Last Christmas I spent hours suspended, floating around in Heathrow, just waiting for someone with tickets to Bali or Honolulu to pass by and breathe me in. Instead I ended up in Birmingham.

Doug the Bug: I hear the United States is fun. Any country without a national healthcare system is an attractive place to raise a family. Besides, the dollar is quite favourable right now.

NI: Why is it that most governments and aid agencies don't seem to take you very seriously and continue to allow you to go about your own business?

Phyllis the Bacillus: That's because we suffer from an additional image problem. Not only are we found primarily in developing countries, but most of our victims are poor people. They can't afford TB medicine or proper treatment.

Doug the Bug: But we are in the process of trying to change that. We're beginning to recognize that it's not how many people you kill, but *who* you kill that's important.



Source: - TB: A Global Emergency/WHO 1994

Sherm the Germ: Exactly! The London press ignored us when we infected hundreds of homeless people. Only when we infected a few badgers on the Prince of Wales' estate did they start talking about us.

NI: So you intend to attack more celebrities?

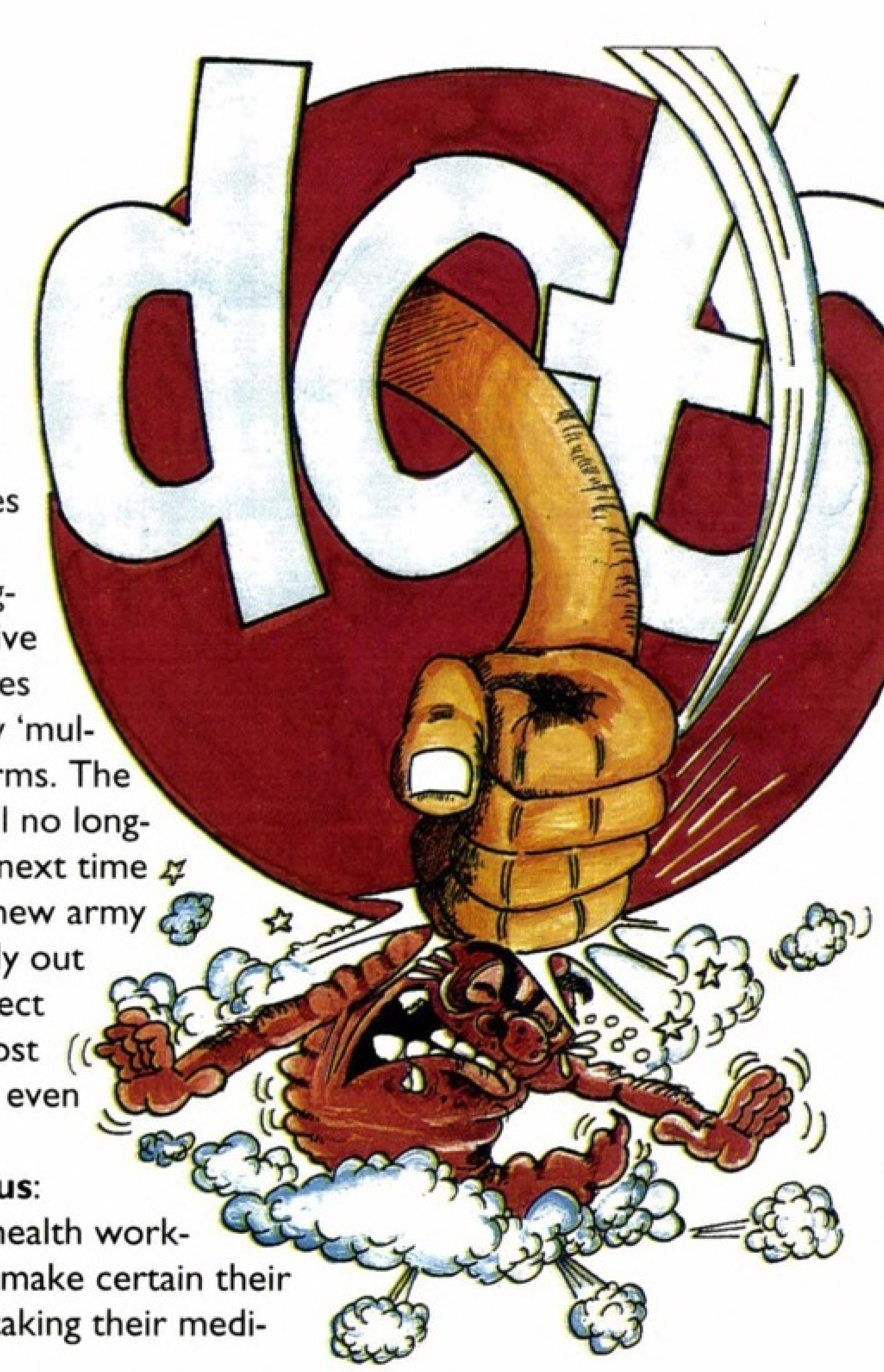
Yvonne the Infection: We've been infecting sports stars, movie stars, musicians and politicians for years. The problem is, when they get sick they can easily afford treatment. Likewise, the élite members of governments aren't personally worried about us. Cancer or heart attacks worry them more. They spend public money on expensive medical equipment and hospitals to take care of the diseases that threaten themselves and their families. So far, knock on wood, they've continued to ignore the inexpensive strategies that could put us out of business for good.

Phyllis the Bacillus: But we think we've found a way to recapture the spotlight.

Doug the Bug: We've been working real hard at becoming drug-resistant! Once the middle and élite classes can no longer cure us, they'll make a great deal of commotion and we'll be back in vogue.

NI: How do you intend to accomplish this?

Kim the Mycobacterium: TB bacilli throughout the world have learned how to hide in specific parts of the lungs during treatment. If the patient doesn't faithfully take all of his or her medicines for the entire six months, our strongest germs can survive in these hiding places and multiply in new 'multidrug-resistant' forms. The same medicines will no longer be effective the next time around. Then our new army of super bugs can fly out of the lungs and infect others when the host coughs, sneezes or even talks.



Phyllis the Bacillus: Fortunately, most health workers don't watch to make certain their patients are really taking their medicines.

Yvonne the Infection: So far our strategy has been very successful. We've become multidrug-resistant in thousands of people around the world, thanks to those governments who don't pay attention to treating us properly.

Phyllis the Bacillus: And someday soon we'll get our first big celebrity victim.

Sherm the Germ: Yes! Someone like Pavarotti! We'll have him bellowing out legions of deadly bacilli into the air when he sings!

Doug the Bug: Imagine the headlines!

Sherm the Germ: People wearing oxygen masks when they go out in public!

Doug the Bug: Benefit concerts for the mTB on MTV!

Kim the Mycobacterium: It will take at least a decade before researchers discover and test new medicines to fight multidrug-resistant TB.

Doug the Bug: And even then we'll be safe. They'll make the same mistake and fail to properly provide these medicines to poor people.

NI: Surely governments have learned from the AIDS epidemic and will not allow themselves to get tricked again by you nasty germs.

Phyllis the Bacillus: Don't underestimate humanity's apathy about the fate of low-income and disenfranchized groups. HIV had years to spread because the humans who control resources didn't care about the fate of gay men, IV drug users and Africans. We're using the same tactic. By the time middle-class citizens and movie stars start dying of multidrug-resistant TB, it will be too late to stop us!

Sherm the Germ: Our comeback is ensured! ■

Johannes Chlamydia is an ethical chiropractor specializing in the teleological suspension of public policy in Copenhagen, Denmark.

ILLUSTRATIONS: DAVID LAZO AGUILAR

ACTION

You can help prevent TB's return to stardom by contacting **The Action Coalition,** a grassroots advocacy network utilizing the Internet to mobilize a response to the global TB epidemic.

THE ACTION COALITION, 19 GRANT AVENUE, TAKOMA PARK, MD 20912, USA. TEL: (301) 270 5565.
World Wide Web at **http://action.org/tuberculosis.html**

H. POWELL / CAMERA PRESS

Target practice

Tim Ensor takes a tour round the ruins of the Soviet healthcare monolith, where basic needs are being left out in the cold.

CEAUSCESCU, THE ROMANIAN dictator, proudly boasted that his policies had made the Romanian people so healthy they had no need for higher spending on medical care. The exposure of widespread abortion used as a means of contraception, hellish orphanages and rising mortality rates gave the tragic lie to this assertion.

Not just in Romania but throughout all 27 countries of the Former Soviet Bloc, from the bright lights of Prague and Budapest to the outer reaches of Siberia, healthcare is in crisis. And Western aid attempts have sometimes caused further pain.

The common tie which bound together such a large and heterogeneous collection of countries was an economic and political system which imposed a single structure on more than 400 million people. Health services were dominated by targets based on inputs – numbers of doctors, nurses and hospital beds, rather than numbers of patients treated or recovered. A hospital would get more money if it increased the number of beds or kept patients in hospital longer and so had more doctors. As a result the Soviet Union had three times as many doctors per head of the population as Britain.

They often ended up doing mundane, unskilled tasks. Most doctors were poorly paid and badly equipped – despite the widely recognized work of centres of medical excellence, which pioneered the surgical correction of eye defects in Russia or the treatment of cerebral palsy in Hungary. In Bulgaria a doctor earned less than half the average wage, while in Romania she – since the majority of doctors are women – might earn less than a cloakroom attendant. Most held down a number of jobs to survive. The soliciting of informal gifts – in kind or in money – reached epidemic proportions. Some doctors were able to earn many times their state salary in this way and frequently kept patients waiting for operations until they made the expected gift.

Family doctors do not exist in the Former Soviet Bloc. Instead patients are assigned to large and impersonal policlinics where they may see a different doctor at each visit. Consumer views and preferences receive little weight. Patients have become used to receiving indifferent and often surly service. This attitude is reflected even in the way Westerners are shown around hospitals; doors are opened and shut with little regard for patient dignity. The newly expanding private sector offers the one element of choice – but only for those who can pay.

Shake-up

In the post-Communist shake-up the number of patients treated has declined and key indicators of health have deteriorated. Infectious diseases like diphtheria, hepatitis and TB, which were previously under control, are now on the increase in Russia and Central Asia. Environmental pollution, widespread cigarette smoking, high alcohol consumption and a large fat intake are increasing the incidence of heart disease, cancers and strokes.

The economies of the region are in a state of rapid change. State factories employing whole towns are closed or shrunk in size, making way for smaller private- and joint-sector companies. Cities from Tallinn to Tashkent sprout well-stocked private-sector kiosks, open day and night, replacing big state-run shops and their meagre wares. Some people have got rich very quickly as evidenced by the growing number of BMWs and Volvos now jostling Ladas, Trabants and Volgas for road-space.

Such change can appear exciting, yet it has its social cost. Poor health conditions have been exacerbated by declining incomes and rising unemployment. The rise in poverty is especially marked in countries suffering from civil war, like Georgia and Armenia. Health budgets have been slashed as government revenue from state companies has dried up. In many countries patients must now bring their drugs, medical supplies, food and blankets with them to hospital.

In Russia much of the old Soviet healthcare structure still remains. But the break-up of the Union has meant that ministries of health in republics previously governed from Moscow are suddenly having to direct policy. In time this could be beneficial, but for now there is a lack of policy co-ordination, particularly in the control of epidemics.

Healthcare for rural communities has suffered too. The Soviet system required all new doctors to serve in rural areas before they were allowed to specialize or move to the cities. This ensured rural access to health workers – even if they were the least experienced. Now these restrictions no longer exist and many doctors have migrated to cities.

There was much that was obsolete about the Soviet system, but it did lead to many improvements in basic health. At the turn of the century around 25 out of every 100 Russian children died before they were a year old – double the British rate at the time. By the early 1960s the figure had been reduced to 2 in 100.

By destroying its old healthcare structure without replacing it with a workable alternative, the Former Soviet Bloc runs the risk of losing such gains. Some countries have already begun to copy the worst Western practices. Those where the reforms first began, like the Czech Republic, have encountered similar problems to the US of spiralling healthcare costs and a proliferation of expensive, minority treatments.

The privatization of hospitals is, in many countries, advanced as a way to encourage competition. But without regulation there is a real danger that hospitals which should provide basic services will choose to offer only luxury treatments. Some already lease parts of their buildings to computer companies or Western drug firms.

Another Western-style reform is the introduction of state insurance schemes that citizens must contribute to in order to obtain services. The funds operate outside the control of ministries of health. Last year a scandal shook the Estonian insurance system when it was revealed that the directors of several funds had invested money abroad without proper accountability.

Ministering angel or cog in Romania's childcare system? (opposite). A nurse gets her priorities right in the former Soviet Union (below).

УГОЛОК СОРЕ
МЫ ПРИДЕМ
К ПОБЕДЕ
КОММУНИСТИЧЕСКОГО
ТРУДА
В.И. ЛЕНИН

BRUNO BARBEY / MAGNUM

In the midst of all this upheaval Western charities, equipment manufacturers and multinational donors have rushed in to provide medical aid. One observer commented wryly that hardly any plane lands in Moscow without a group of Western experts disembarking to tout their own vital product or a panacea for the health system.

Some doctors frequently kept patients waiting for operations until they made the expected gift

Stories abound of countries being given pharmaceuticals past their sell-by date. Equipment donated by Western companies often turns out to be a clever sales ploy, earning many times its original value from spare parts and maintenance over the years.

The plight of Albanian and Romanian orphanages stirred public sensitivities abroad and led to an outpouring of aid. But many argue that such money has gone to prop up a discredited system for getting rid of unwanted children. The lack of co-ordination of this aid and the resentment that local inhabitants feel, when they see the living standards in these institutions far exceeding their own, raise further questions. Aid has had a beneficial impact as well, but there is resentment that Western largesse has been handed out in indiscriminate and unthinking ways.

Stark contrast

The number of private clinics that provide services outside office hours, offer appointments and give courteous services to patients is growing rapidly, providing a stark contrast to the state alternative. There is a need for the health service to harness this dynamism. Inevitably this will mean concentrating resources on fewer facilities and personnel, creating widespread medical unemployment. Pumping resources into the health sector is not a realistic option in view of the economic shambles.

As in other parts of the world, the Former Soviet Bloc must focus much more on which treatments are effective in order to make maximum use of the very scarce resources available. The health sector in these countries has the opportunity to introduce radical policies that emphasize illness prevention and health promotion. The alternative – unregulated privatization and a continued decline of the state sector – will sustain ineffective, unnecessary treatments and, when it comes to basic healthcare, leave most of the population out in the cold. ■

Tim Ensor is a research fellow at the Centre for Health Economics, the University of York, England.

HEALTH – THE FACTS

TODAY'S WORLD IS NOT A PICTURE OF HEALTH. Increases in longevity and improved child survival have been overshadowed by an ever-widening gap in health between rich and poor.

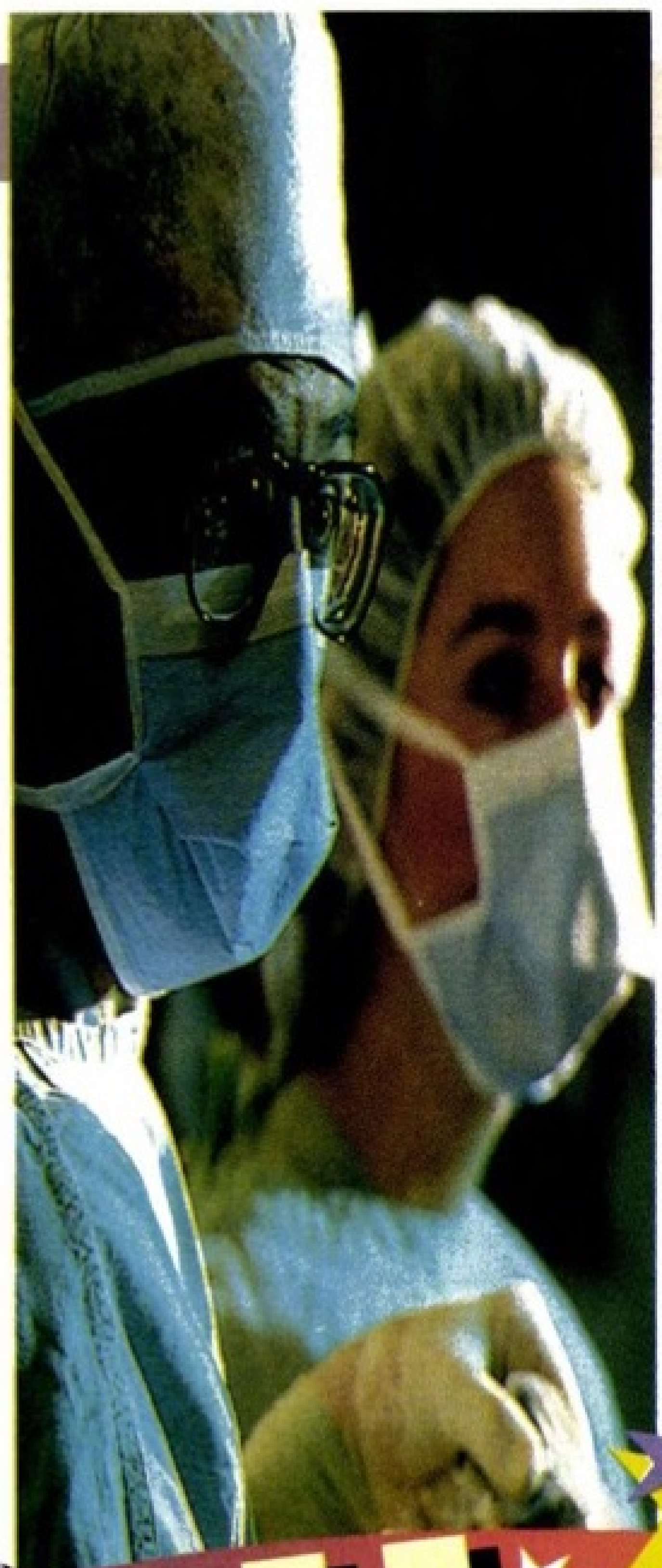
But there have been some gains. Eight out of ten children have been vaccinated against the major childhood killers. And between 1980 and 1993 infant mortality fell by 25% and overall life expectancy increased by more than four years.

GREAT EXPECTATIONS

POVERTY, ACCORDING TO THE WORLD HEALTH ORGANIZATION, IS THE WORLD'S DEADLIEST DISEASE. The wealth-health gap for under-fives is remarkable – in some rich countries 6 out of every 1,000 children die before the age of five, whereas in 16 low-income countries the rate is over 200 per 1,000. In Niger it is 320 per 1,000.

Life expectancies are nearly twice as high in rich countries as they are in poor ones. In five of the poorest, life expectancy will *decrease* by the year 2000, while in some of the richest it will increase from around 76 to 79 years. The relationship between life expectancy and GNP is obvious, as the chart (left) shows.

Country	GNP per capita $US 1992	Life expectancy at birth Years 1993
Japan	28,190	79
Canada	20,710	78
Australia	17,260	77
US	23,240	76
Britain	17,790	76
Aotearoa/NZ	12,300	76
Nicaragua	340	66
South Africa	2,670	63
Kenya	310	59
Bangladesh	220	53
Uganda	170	43

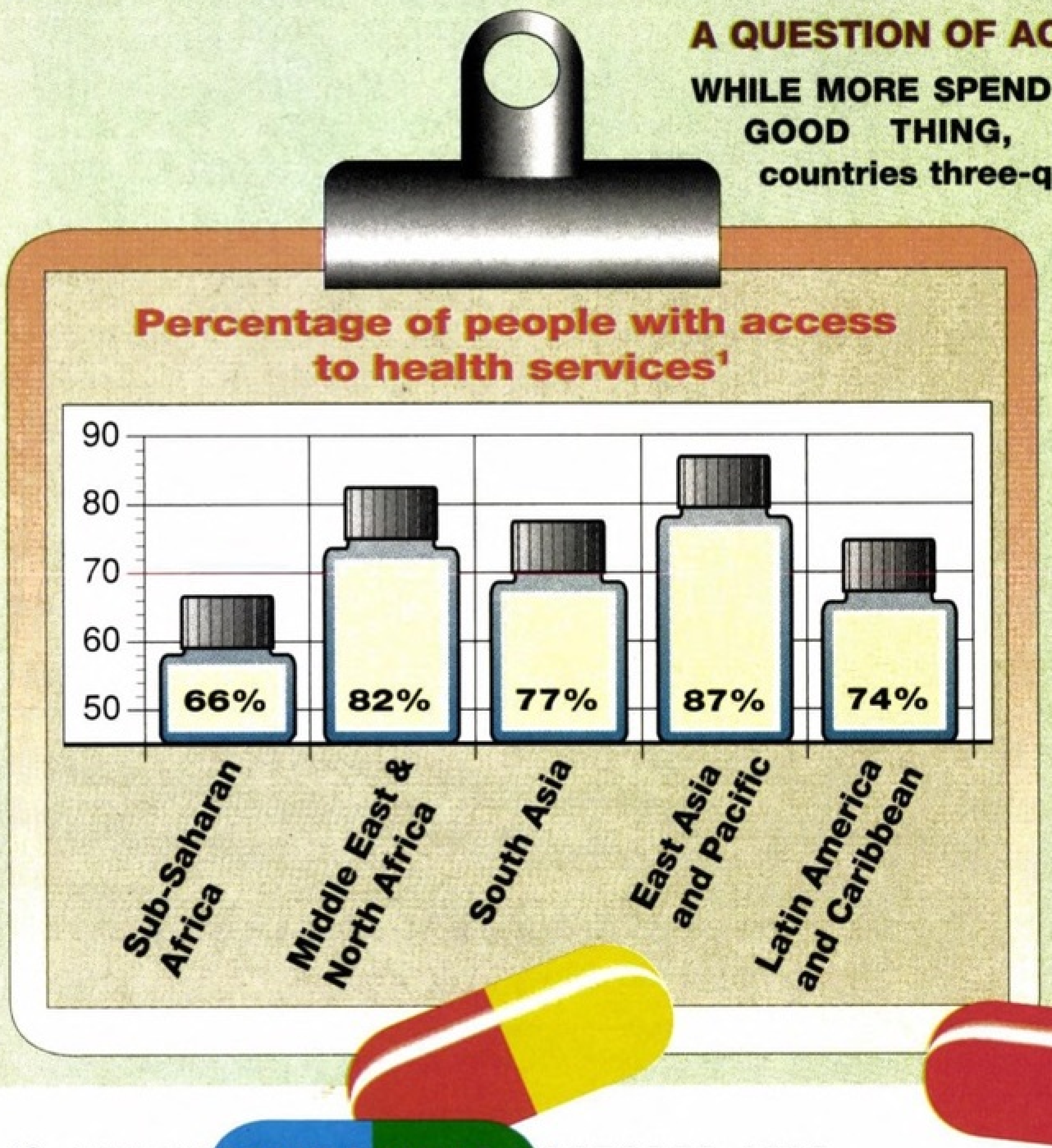


HEY BIG SPENDER

THERE ARE BIG DIFFERENCES IN THE PERCENTAGES THAT GOVERNMENTS SPEND ON HEALTH – though the percentages translate very differently into actual money – for example, Costa Rica spends $132 per person on health but 32% of its budget while Canada spends $1,945, which is only 5.2% of its budget. Most regions in the Majority World can only afford to spend between 2% and 6% of their budgets on health, while industrialized countries spend nearly twice that amount – 13% on average.

A QUESTION OF ACCESS

WHILE MORE SPENDING ON HEALTH IS A GOOD THING, in most Southern countries three-quarters of healthcare goes to the cities, whereas the majority of the population lives in rural areas – and therefore has limited access to health services. Three-quarters of deaths in these countries could be prevented by primary health-care, but most of the budgets go on expensive cures.[2]



KILLERS

THE LARGEST NUMBERS OF DEATHS are through communicable and, often, treatable diseases. Combined with deaths related to childbearing they account for 40% of global deaths: 99% of these occur in the Majority World.

Former 'diseases of prosperity' such as cancer and heart disease are now equally split between the 'developed' and 'developing' world. This is mainly due to the spread of pollution and fatty diets in the South. Smoking kills three million people a year and is the largest single preventable cause of death. There are many diseases which don't always kill but which worsen the quality of life for millions. Each year, diarrhoea affects 1.8 billion children under five, and sexually transmitted diseases affect 297 million new people.

DRUGBIZ

A SIGNIFICANT PROPORTION OF THE WORLD'S DRUGS ARE EITHER USED INAPPROPRIATELY OR DON'T WORK.

◆ An estimated $9 billion is wasted every year because of the irrational use of antibiotics.[3]

◆ Two-thirds of all drugs used by children may have little or no value. $1 billion a year is wasted on useless antidiarrhoeal drugs and cough and cold remedies, mainly in the Majority World.[4]

◆ German companies sold 65% of their irrational drugs in 1991/92 exclusively to the Majority World – these drugs could not be sold in Germany.[5]

◆ Cheap effective remedies are often overlooked. Iodine-deficiency disorders cause 30,000 stillbirths each year and over 120,000 babies are born with severe disabilities. The solution – iodizing salt supplies – costs as little as $0.05 per person per year.

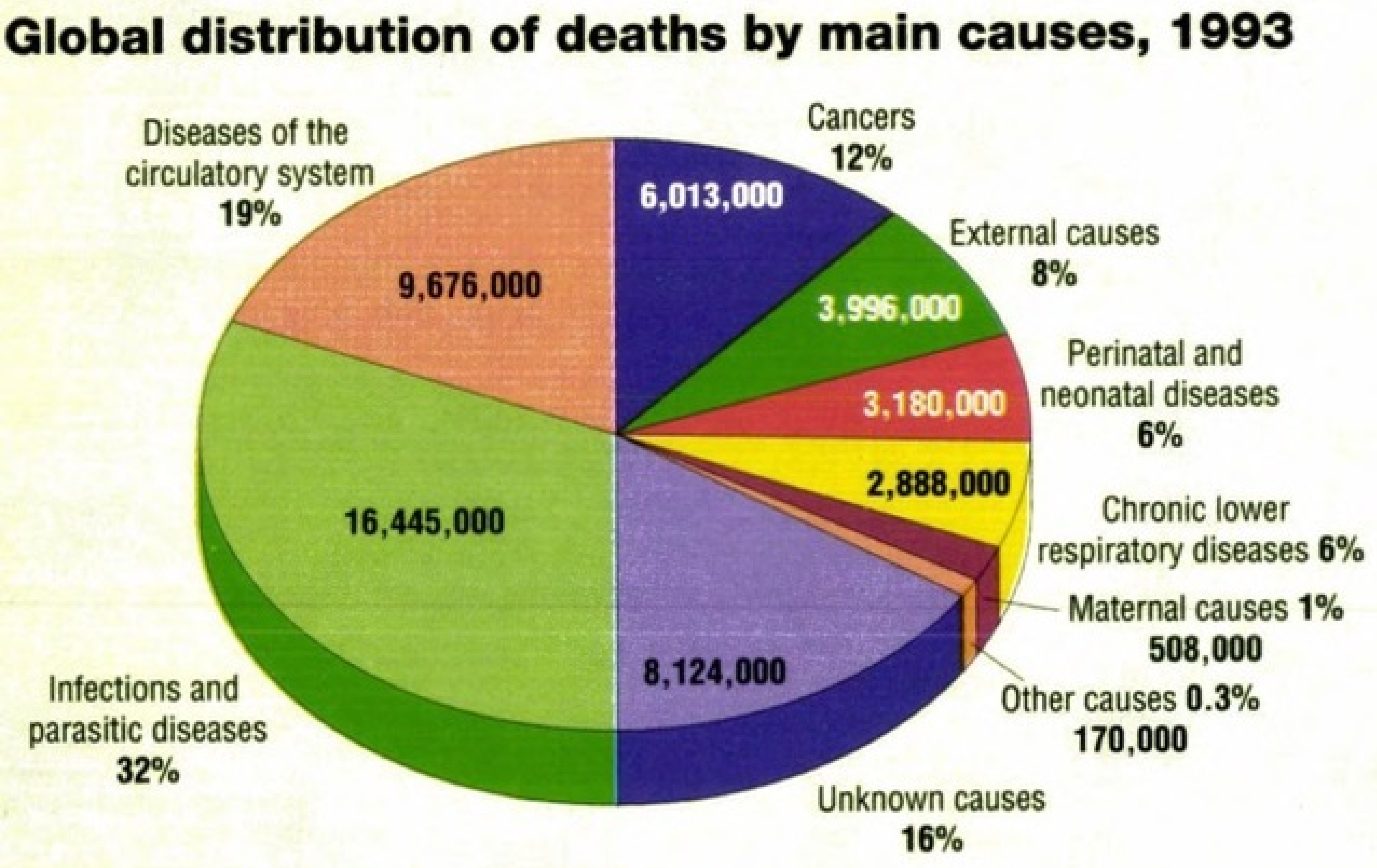
ALL IN THE MIND

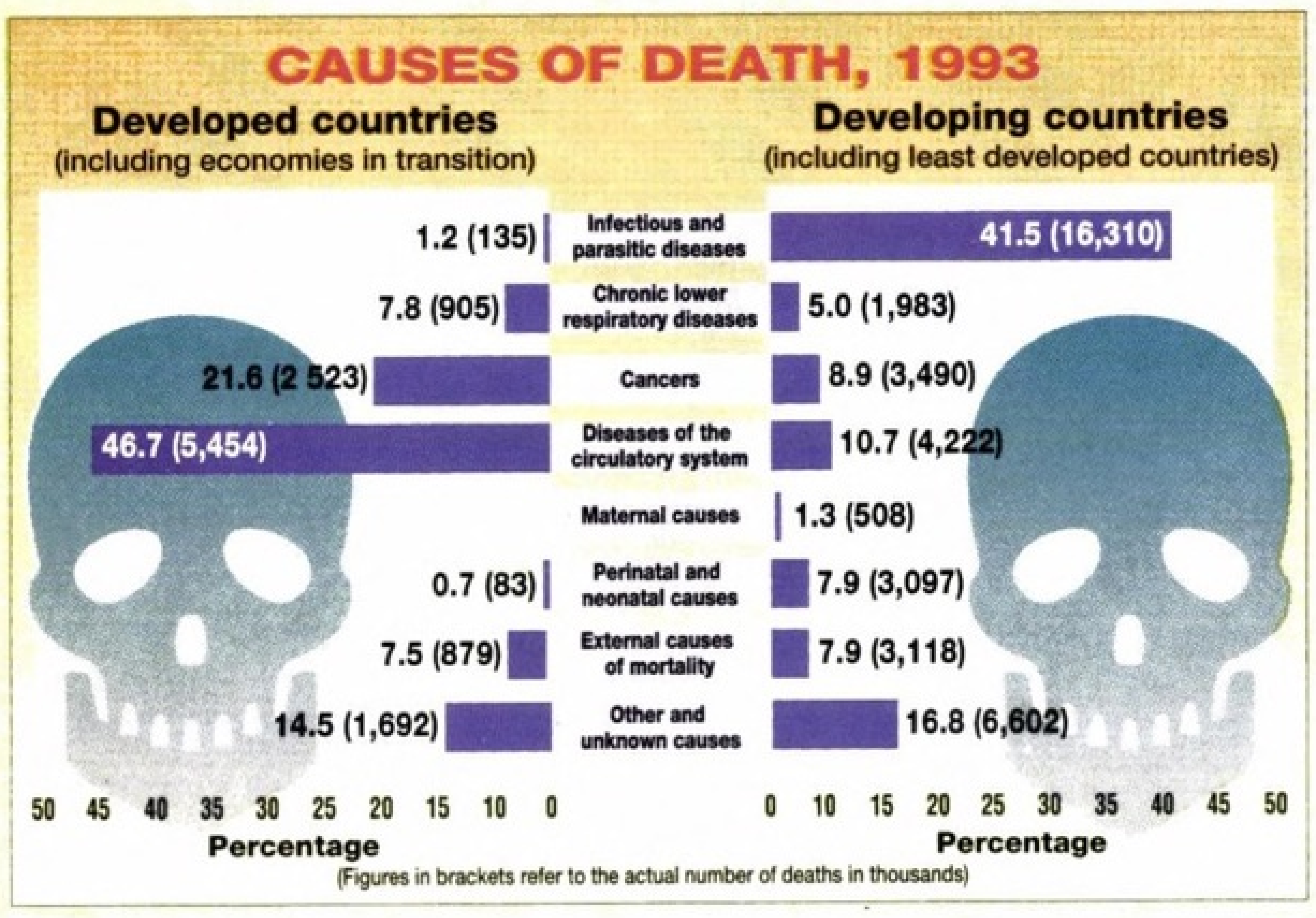
MENTAL ILL HEALTH IS AT THE BOTTOM OF MEDICAL PRIORITIES, WITH SEVERE CONDITIONS GETTING MINIMAL CARE EVEN IN WEALTHY COUNTRIES. YET:

◆ Some 500 million people suffer from neurotic, stress-related and psychosomatic disorders.

◆ Some 200 million more suffer from mood disorders, such as depression, with 59 million people disabled.

◆ Around 150 million people suffer from congenital mental conditions.


Global distribution of deaths by main causes, 1993

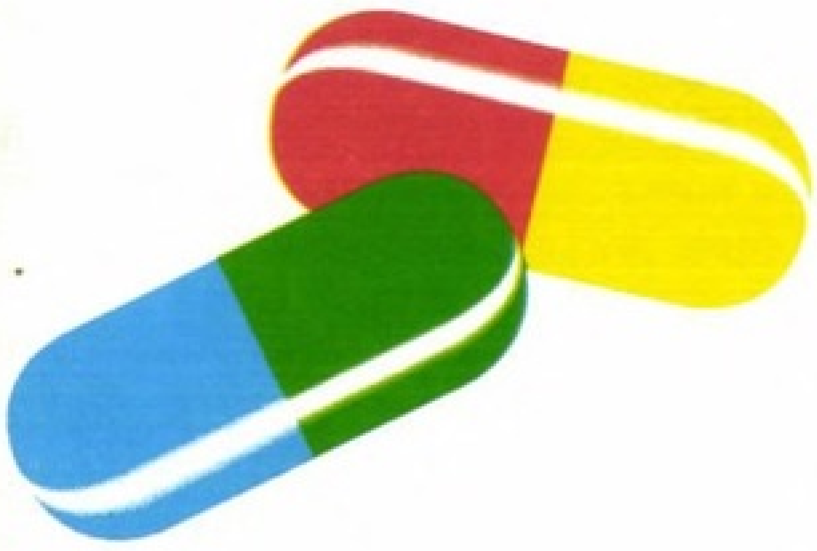

CAUSES OF DEATH, 1993

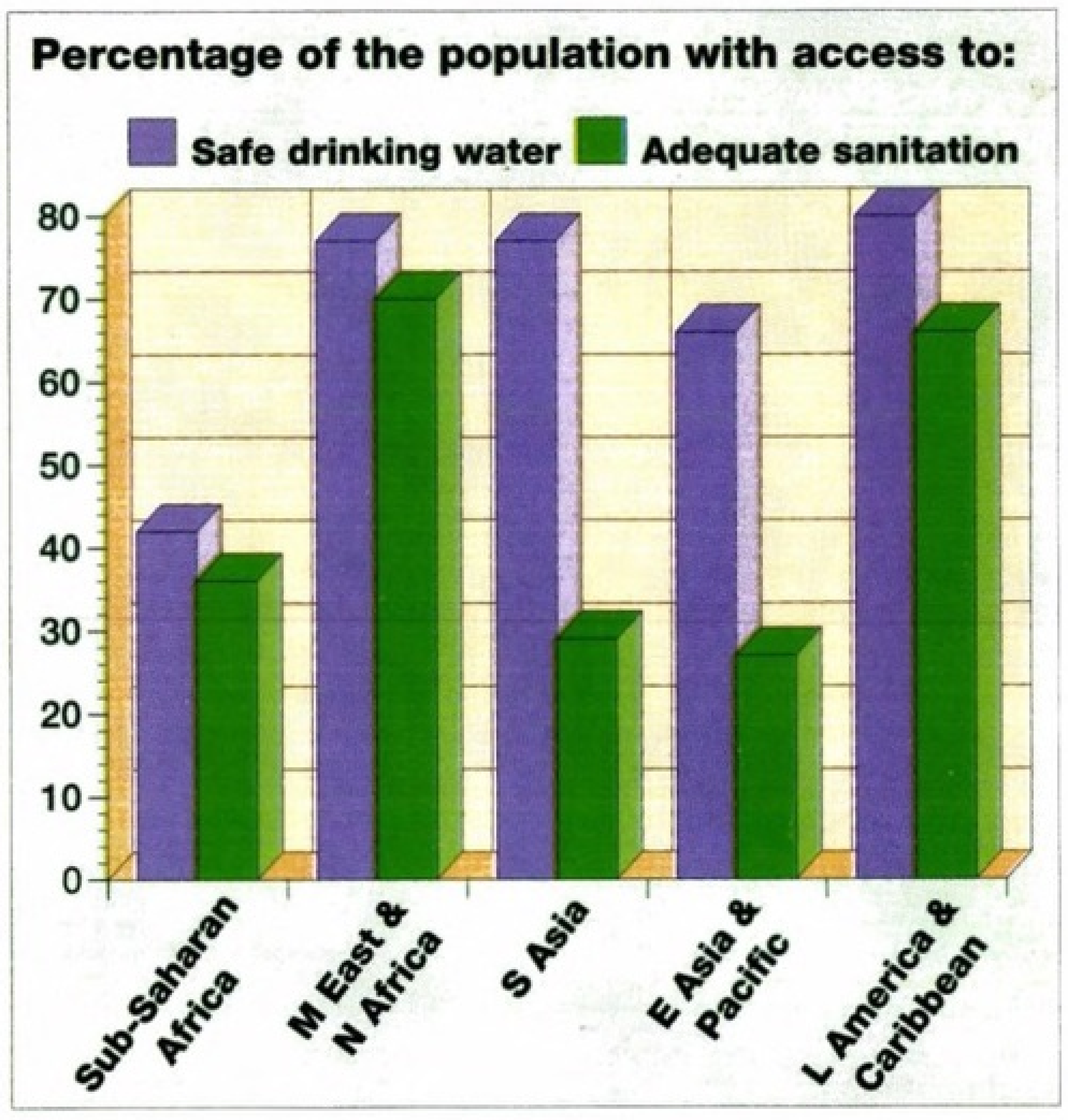
(Figures in brackets refer to the actual number of deaths in thousands)

CLOCKWISE TOP LEFT: S RESNICK / SABA-REA; DAVID RANSOM; STUART FRANKLIN / MAGNUM

WATER TREATMENT

THE MAJORITY OF THE WORLD'S POPULATION LACKS ADEQUATE SANITATION, thus providing good conditions for infectious diseases to spread. The lack of safe drinking water leaves the channels open for water-borne scourges.



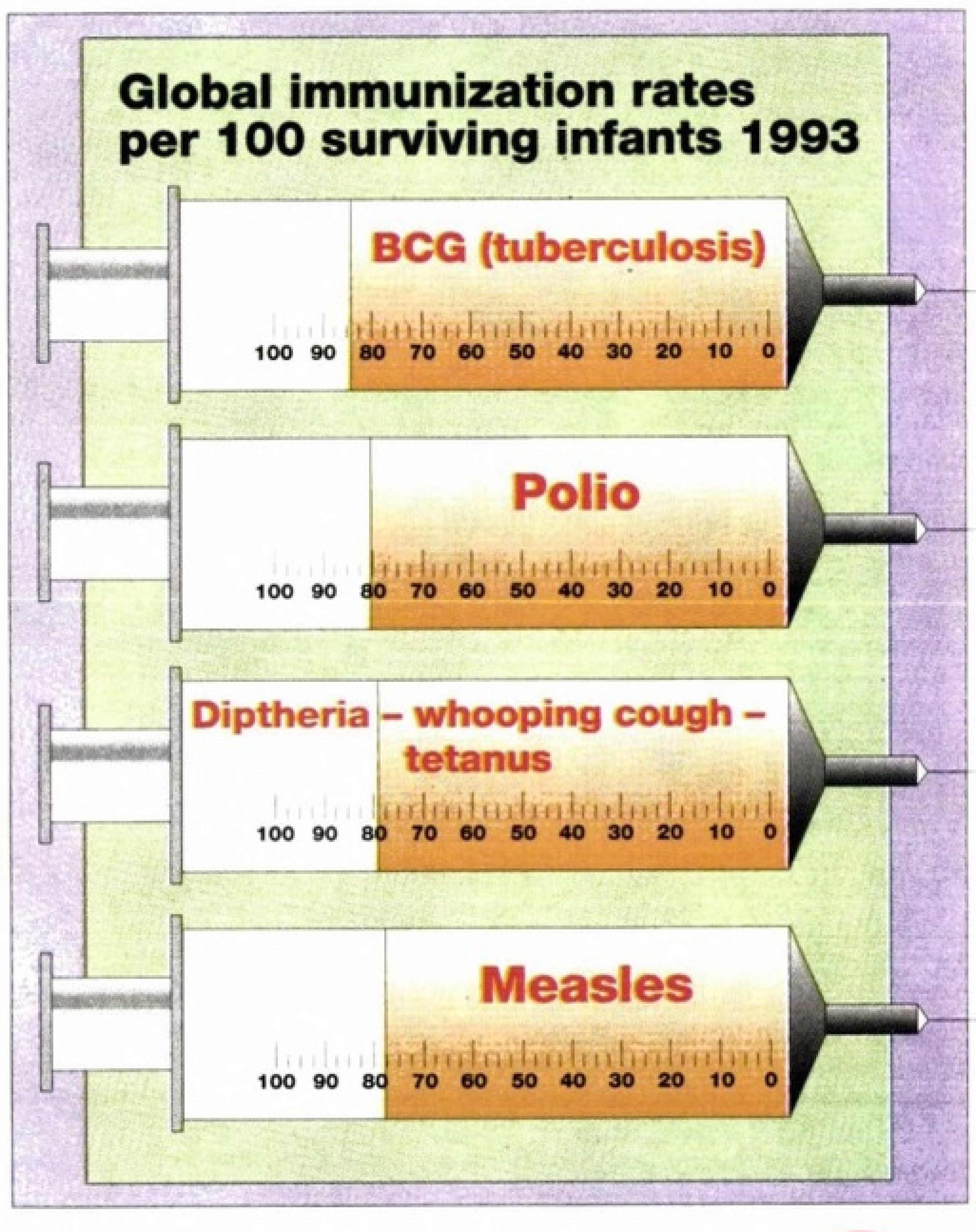

Percentage of the population with access to:

WORKING IT IN

- ◆ Some 120 million occupational accidents with more than 200,000 deaths are estimated to occur every year.
- ◆ Each year there are between 68 and 157 million new cases of work-related diseases.
- ◆ More than 30% of workers in industrialized countries complain about stress and overload. The total economic loss amounts to 10-15% of GNP in these countries.[6]

IMMUNITY

WORLD GOALS ARE TO IMMUNIZE AT LEAST 90% OF THE WORLD'S CHILDREN AND 90% OF WOMEN OF CHILD-BEARING AGE BY THE YEAR 2000. But the gains of the last two decades are now being eroded by apathetic policies. Immunization rates in Africa are only around 50%. Inner cities of many industrialized countries have immunization rates lower than those in 'developing' countries. Around 2.4 million deaths of children under five are still due to vaccine-preventable diseases. The efficacy of vaccines themselves is now under fire in the West.


Global immunization rates per 100 surviving infants 1993

All facts, unless otherwise noted, are taken from the World Health Organization's *World Health Report 1995: Bridging the Gaps* (WHO, Geneva). **1** *State of the World's Children 1995* (UNICEF). **2** *The Ethical Consumer: Special Report on the Pharmaceutical Industry*, No 32, November 1994. **3** *Superbug: Nature's Revenge* G Cannon (Virgin Books, London 1995). **4** *Scrip*, No 1633, 12 July 1991. **5** *An Alternative Report on Trade* ICDA (Brussels, 1995). **6** *In Point of Fact* WHO, No 84, April 1995.

How shall we live?

Amanda Hazelton describes her search for healing beyond 'slash-and-burn' medicine and makes a connection between cancer and clowning.

ILLUSTRATION: SARAH JOHN

I KNEW SOMETHING WAS wrong when my blood-test result came back indecently fast and my GP asked me to 'pop along after surgery'. It was 'terrible news', she said: I had leukemia. It felt like being struck by lightning. It was 1985 and I was nearly 28. Oddly enough I spent much of the consultation mopping the doctor up. Contrary to popular imagination GPs rarely have to tell young patients that they have potentially fatal diseases. It was her 'first time', and I remember thanking her profusely for being so brave.

'It means a lot of hospital for a long time,' she said, and sure enough I spent the next morning in haematology outpatients being prodded and pushed and having unspeakably horrible things done to get a bone-marrow sample. They were very nice at the hospital and took the trouble to explain. Leukemia is a form of cancer. No-one knew exactly why, but the cells in my bone-marrow had mutated and started over-producing blood. My white blood count was over 300 when it should have been below 10, and I had hundreds too many platelets, which was why I kept getting bruises. There are many types of leukemia, some acute and some (like mine) chronic. With drug treatment it could be controlled and life would feel normal, but nobody knew for how long. If the disease became malignant – as one day it undoubtedly would – there was not a lot that medicine could do to prevent a speedy demise.

Life was never going to feel normal again – at least not the kind of normal I knew then. I began to live with an extraordinary conundrum: I had a life-threatening illness, but I was not exactly ill. The world calls these conditions 'terminal', yet they are no more terminal than life itself. Nevertheless there is always an awareness that terminal illness could be just around the corner; it focuses the mind wonderfully.

In the aftershock my preoccupation with life (how long?) and death (when and how?)

begged the real question, which is *how shall I live?* I kept my sense of humour but part of me was screaming. How could I not have 'noticed' that my spleen had swollen down to my navel, and that I was very, very tired? I just hadn't allowed myself to notice. Like so many of us I was not educated in the art of well-being, only in the appearance of compulsory OK-ness. At the hospital there was no information about where to seek help with these existential questions. My terribly nice (and good-looking) registrar went red when I asked about counselling: 'Only when you're terminally ill... near the end,' he murmured. This is not true of every hospital department of course, but I reckon my experience is quite usual and support is random.

In a hospital setting even the strongest of us is liable to surrender our autonomy to the magic white coat. I admired what they knew about my chromosomes and to some extent I was relieved to be swept into this benevolent patriarchy. The system expected and offered nothing more than for me to turn up for blood tests, take the medicine and live as 'normally' as possible, which indeed is all that many patients wish to do.

But another way opened up for me. My librarian housemate rushed home with a pile of useful books. Among the devastating 'factual' tomes which charted the course of a hundred different cancers was a personal account of the Bristol Cancer Help Centre where it is acknowledged that cancer affects everything about us, not just bits of our bodies. We can be disempowered and bewildered as patients, but the book argued that if we took charge of our lives illness could even be an enriching experience. I booked a day at the Bristol Centre, and my eyes were opened to all sorts of things – to dietary therapy, relaxation and meditation, spiritual healing, and to the fact that I was allowed to make choices, to behave as if I mattered.

Emerging from this reorientation I proclaimed the virtues of what I had until then called self-indulgence. It was OK to relax, really *stop*, not just watch TV; OK to go for what felt right, even if others thought it bizarre; to spend time discovering who I really was deep inside, and where I wanted to go. Wow! Everyone should do this. Oh no, said a lot of my friends and colleagues. It's all right for you to do that because you're ill. You've got far harder things to deal with. It would just be selfish for us. How deeply ingrained this kind of Self-denial seemed to be! It was OK to give, but not to yourself. From my new perspective this seemed potentially dangerous.

Nonetheless friendships grew deeper and more vital. I was lucky: nobody dropped me; nobody looked the other way as so often happens when a serious illness is diagnosed. But beyond my close circle I met the 'poor you' syndrome ('Poor you, but you *look* all right'; 'Oh, you *must* be feeling awful'). Mostly genuine concern, but underneath is all that horror about illness and death for which we have no honest language. As soon as you are life-threateningly ill you become a repository for others' death fears: as good as dead, except, of course, that you *must not die* because death is a sign of weakness, a failure for the medical science in which we place our faith, and a reminder that it's going to happen to all of us and we are in no way prepared. I still don't know how to respond to unsolicited sympathy.

Life began to feel like a quest. I negotiated the hospital world which was often kind, wise and humorous and occasionally patronizing and infuriatingly arrogant. I took drugs by mouth, and injected myself with Interferon which made me feel as if I had 'flu all the time. I even spent nine weeks in isolation having all my bone marrow (and most of the rest of me) temporarily wiped out in the name of 'slowing down the disease process'.

The hospital world is limited by the assumption that you will go through medical hell ('slash-and-burn medicine' as it was once described to me) just to survive, and that nothing else really counts. But this ignores what I see as the nature of healing. I was grateful for medicine, but I needed more. I needed to find meaning and adventure, to plumb the mysteries of life, to fill some of the gaping holes that hospitals do not even pretend to patch up. I would have loved to have had a massage while languishing in hospital, and couldn't the gentler natural therapies have helped? And yes, I have met doctors who are open to all this, and who have looked me in the eye and said: healing is a mystery, we know nothing and nobody can say with certainty how a person's life, or their illness, will progress.

My thirst for discovery took me into the 'mind-body-spirit' world. This can seem a confusing, new-age market-place offering every kind of salve and inner journey if you can find your way through the over-bright smiles, bogus claims and rainbow colours – and if you have the cash. However, there is gold to be found if you are selective. Swollen like a balloon with excess fluid from drug side-effects which the hospital could do nothing about, I tried acupuncture and dietary therapy which both helped. And now that I see a homeopath I feel better than I have for years.

I did relaxation and visualization exercises to try and reach a wisdom beyond my over-educated intellect. I joined support groups. My relationship life went crazy. I read books which identified a link between serious illness, spiritual malaise and neglect of our creativity and deeper needs. This took me into therapy – to find where I had lost that part of myself, and when I was ready I explored all sorts of creative avenues until I realized that I wanted to play and sing and be a clown. This has blossomed into a strange kind of vocation. Religious education had taught me little about spirituality, but healers and other inspiring teachers have helped me to reach a strong sense that there is a great deal beyond the world I know. I still have the illness and I still take the drugs, but in many ways I feel healed.

There are still huge challenges to negotiate. How, for instance, do you tell a new partner that you have a life-threatening illness? And a potential employer? Unexpectedly out of work, I've been poring over job descriptions, alarmed at the challenge of selling myself and offering guarantees about what I can achieve and when. Chronic leukemia rarely causes trouble in itself, except that years of drug treatment and stress do take their toll. Applying for a job confronts me again with the question; am I a 'normal', 'useful', 'paying-my-way' member of society, or a non-person, a patient forced into passivity, who cannot expect to contribute and who must wait for what is dished out financially, medically, socially?

It was 'terrible news', she said: I had leukemia. It felt like being struck by lightning

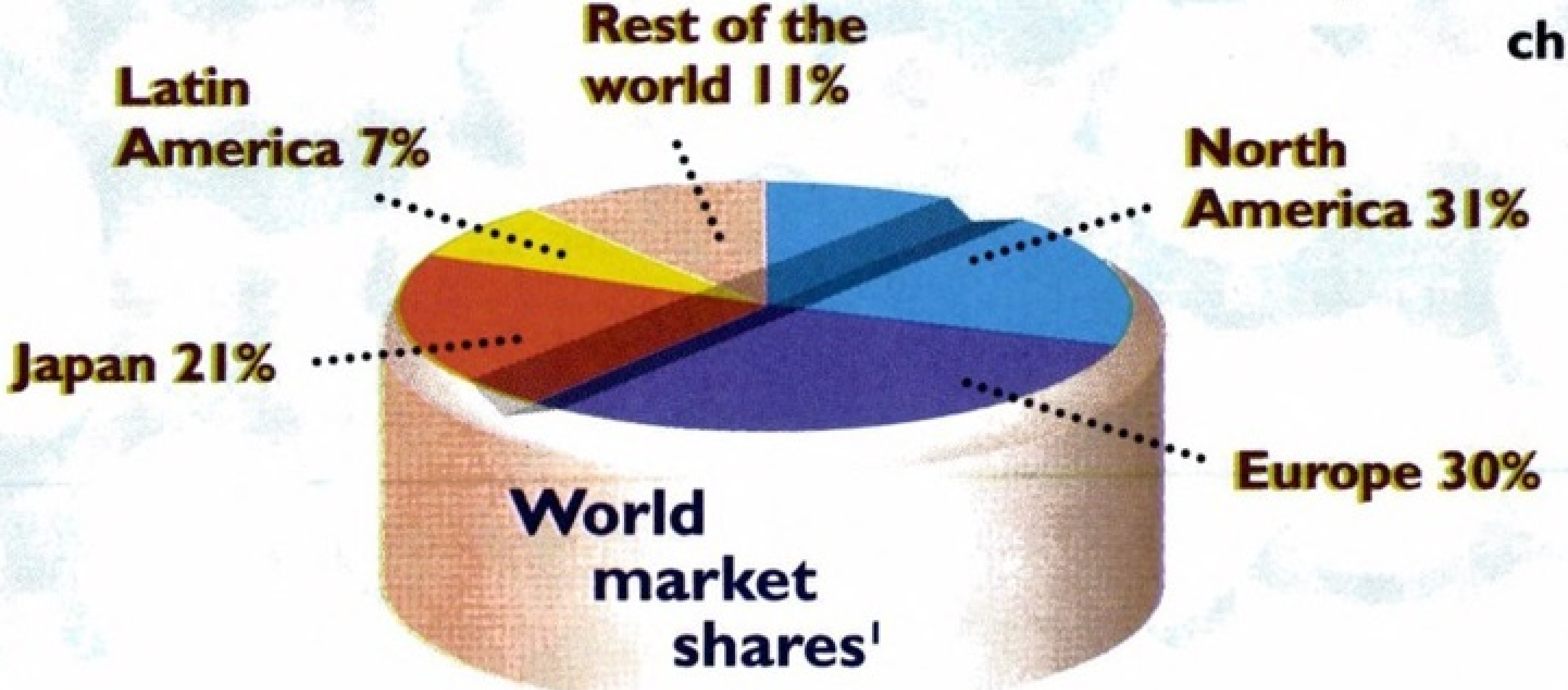
And what if the truth lies somewhere in between? People like me, who can hack it most – but not enough – of the time tend to fall through cracks; not disabled or incapable, yet having to swim twice as hard to stay afloat, which doesn't make sense when we need to take care of ourselves more than most. That's why being a clown, a vulnerable clown with an open heart, is part of survival for me. Life is unpredictable and gives you knocks, but the clown's way is to transform that into treasure, be it glorious and funny or sad and painful, and to live as fully and richly as possible with all the cracks and contradictions. ■

Amanda Hazelton worked for a development agency for 14 years and is now a freelance writer, cook and clown.

Pill Pushers, Drug Dealers

Andrew Chetley looks at the crazy world of the drug industry.

The global pharmaceutical industry's annual sales amounted to $256 billion in 1994.[1] That's more than the total health expenditure of all 'developing' countries plus the former socialist economies of Europe ($219.3 billion).[2] Inevitably the rich world controls the major chunk of this trade.



World market shares[1]

Glaxo Wellcome is kingpin with estimated annual sales of $14 billion.[3] It makes the world's best-selling drug – Zantac, an anti-ulcer treatment – which earns it $3.6 billion, more than the entire Gross National Product of countries like Nepal or Jamaica.[4]

Research – cure or profit?

Total world spending on research and development of new drugs was estimated at 14.6 per cent of sales in 1990. But most of this money went on the development of drugs – the saleable items – and less than a tenth was devoted to pure research.

Most of this research produces 'me-too' drugs – add-ons to existing preparations rather than innovative products which are expensive and risky to develop.

- A seven-year survey of 'new' drugs by the US Food and Drug Administration found that 3 per cent made an 'important potential contribution to existing therapies'; 13 per cent made a 'modest potential contribution' and 84 per cent made 'little or no potential contribution'.

Most drugs are developed in the West. Less than four per cent of research money goes to finding treatments for diseases prevalent in the Majority World where three-quarters of the world's population live and die.[2]

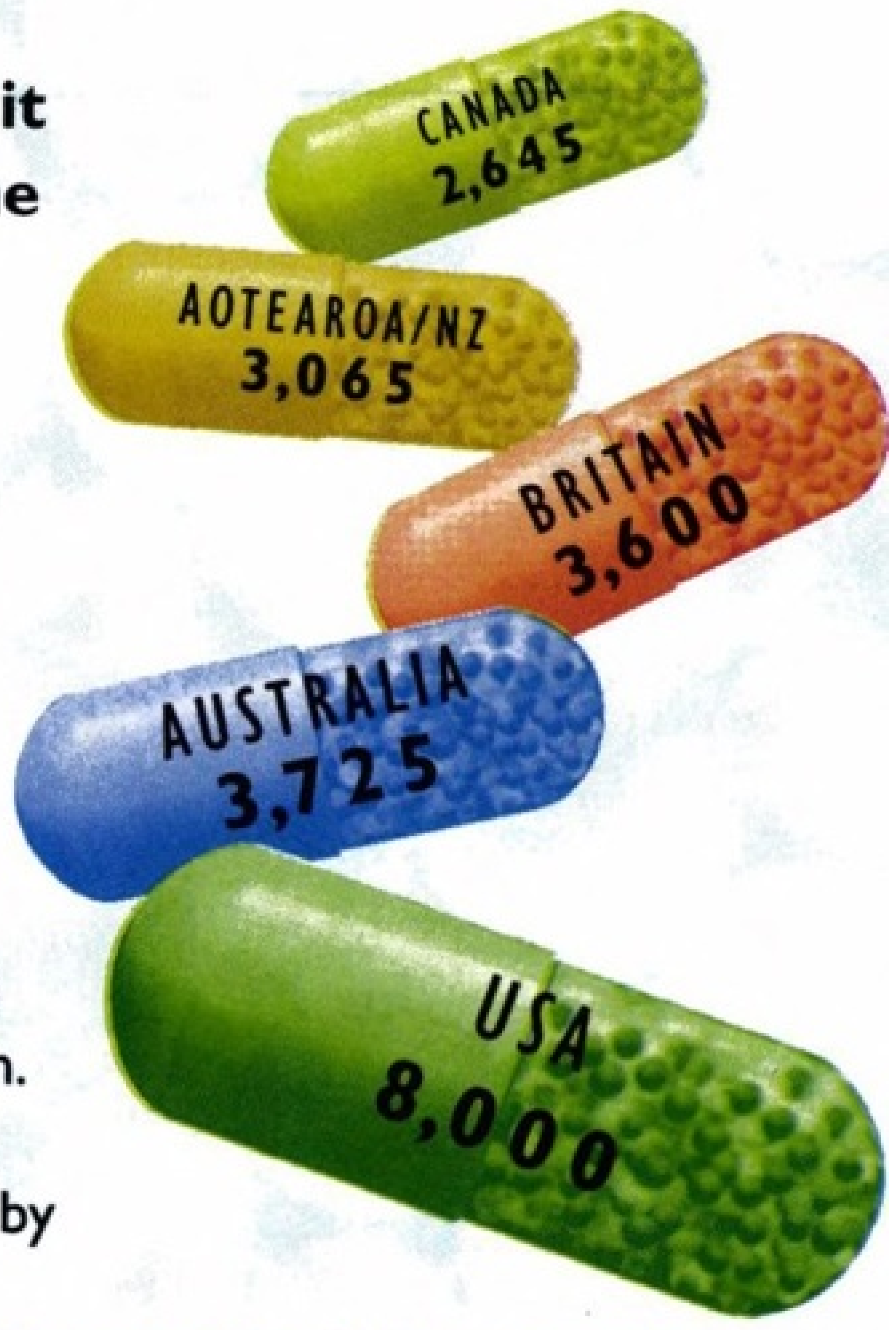
- It is in the companies' interests to develop treatments which involve long-term drug use rather than finding cures. A study by the British Department of Health concluded that research was being 'directed toward commercial returns rather than therapeutic need'.[5]

Drug pushing

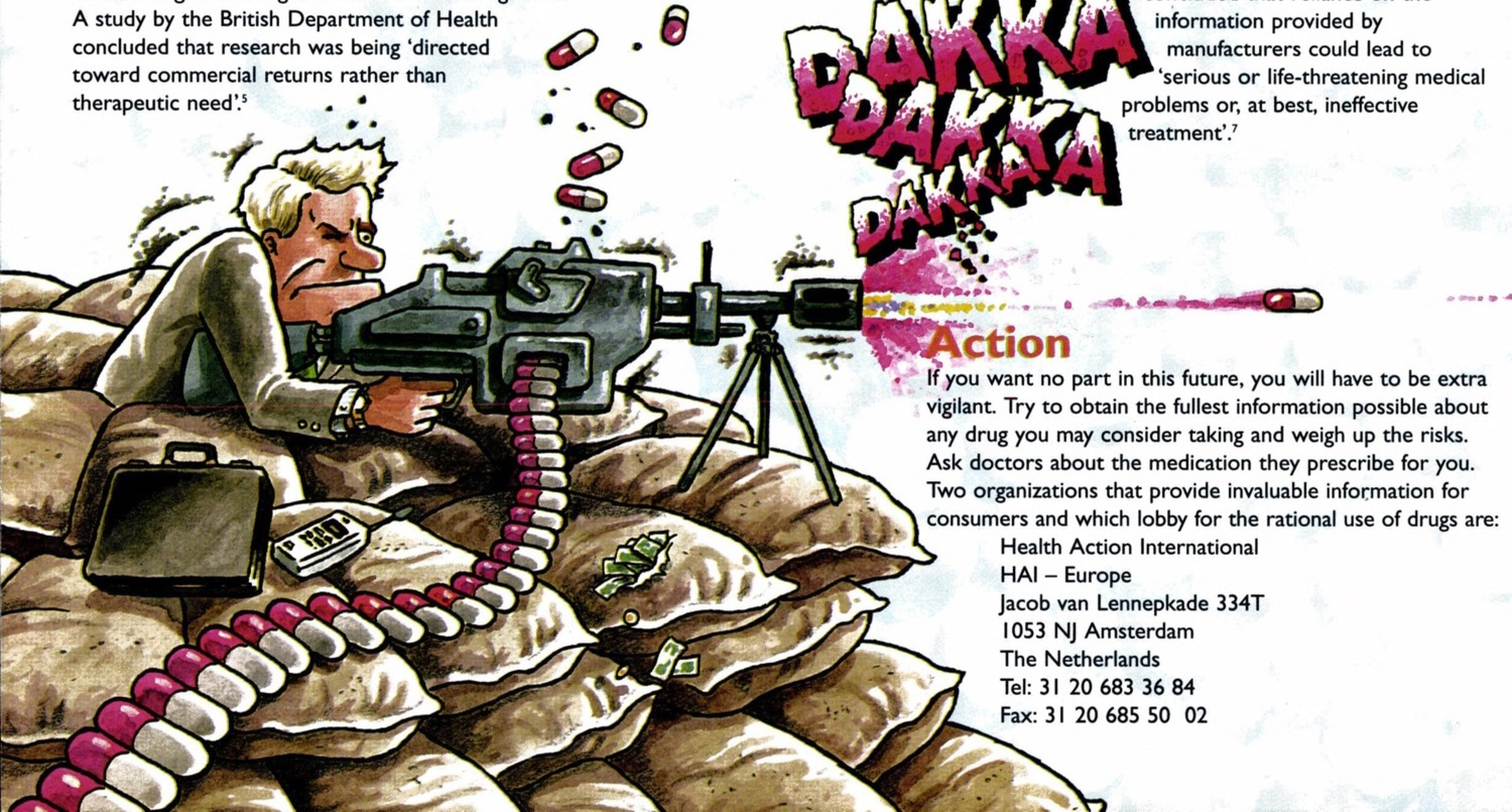
About twice as much money is spent by pharmaceutical companies on promoting and marketing their drugs as on researching them. This involves careful wooing of health professionals. Drug multinationals restricted by law in the West have a field day handing out free samples and 'sweeteners' in countries with more lenient legislation.

Marketing the product can lead to blatant and dangerous misinformation:

- The Office of Technology Assessment (OTA) of the US Congress found that the label and package inserts for at least half of a sample of products sold by US-based companies in Brazil, Kenya, Panama and Thailand failed to provide sufficient information. The OTA concluded that reliance on the information provided by manufacturers could lead to 'serious or life-threatening medical problems or, at best, ineffective treatment'.[7]



Amount in dollars spent by the industry on promotion per doctor per year [6]



Action

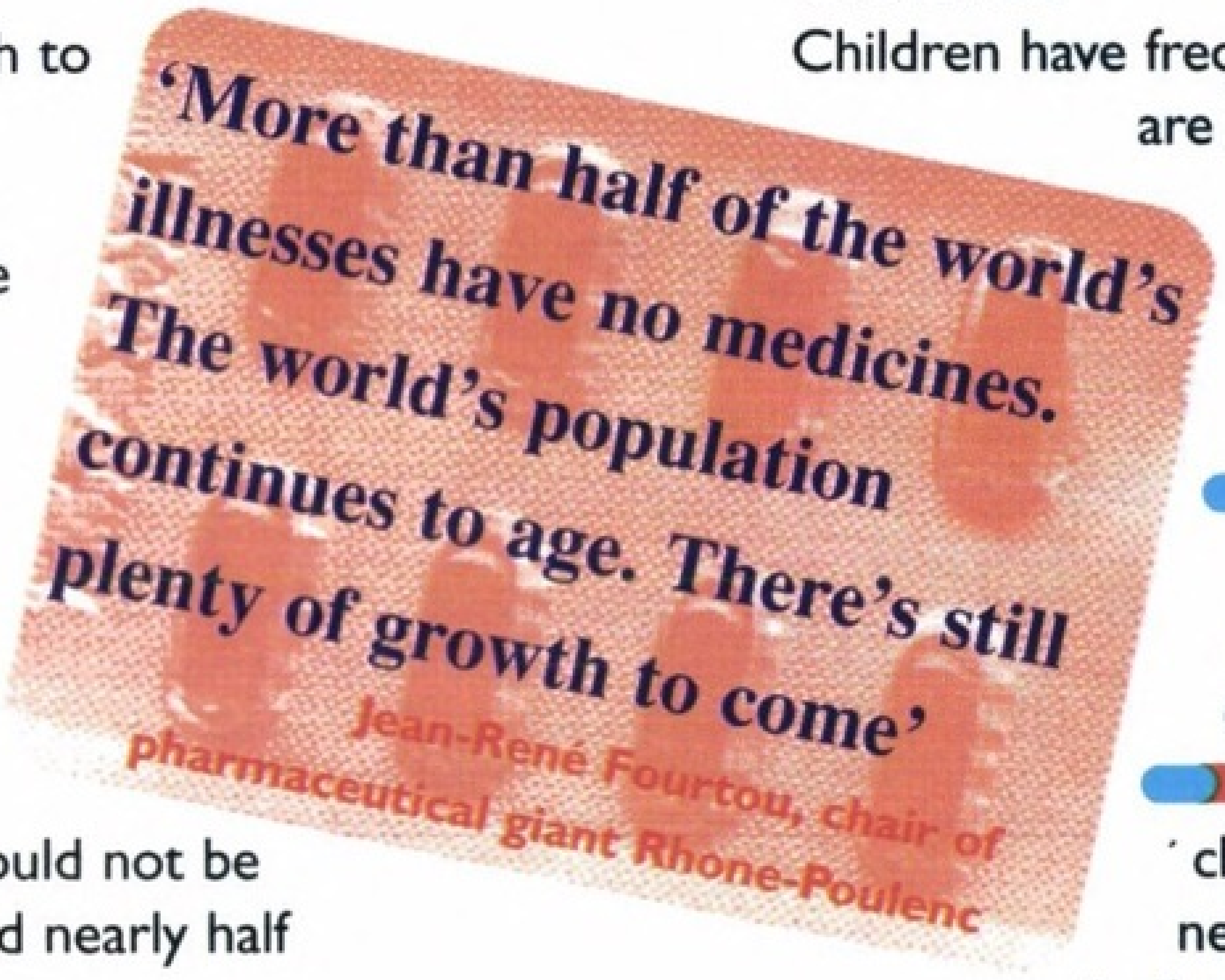
If you want no part in this future, you will have to be extra vigilant. Try to obtain the fullest information possible about any drug you may consider taking and weigh up the risks. Ask doctors about the medication they prescribe for you. Two organizations that provide invaluable information for consumers and which lobby for the rational use of drugs are:

Health Action International
HAI – Europe
Jacob van Lennepkade 334T
1053 NJ Amsterdam
The Netherlands
Tel: 31 20 683 36 84
Fax: 31 20 685 50 02

Who needs essentials?

The WHO lists 270 chemical substances that are enough to meet the world's basic health needs. But the market is flooded with as many as 100,000 drugs. However, up to half the world's population are too poor to buy even the essential drugs they need.[8]

A survey by Health Action International which covered Africa, Asia, Latin America and the Caribbean found that four out of every five antidiarrhoeal products were useless, four out of five cough and cold products had ineffective ingredients, while one in two had ingredients which could cause harmful reactions. More than four out of every five vitamin preparations could not be recommended, with half being irrationally formulated and nearly half containing excessive dosages.[9]



> 'More than half of the world's illnesses have no medicines. The world's population continues to age. There's still plenty of growth to come'
>
> Jean-René Fourtou, chair of pharmaceutical giant Rhone-Poulenc

Soft targets? Women, children and the elderly

The drug companies target sections of the world population they think are particularly vulnerable to their hard sell. Women, children and the elderly population are in their gunsights and that means at least two-thirds of the world's population.

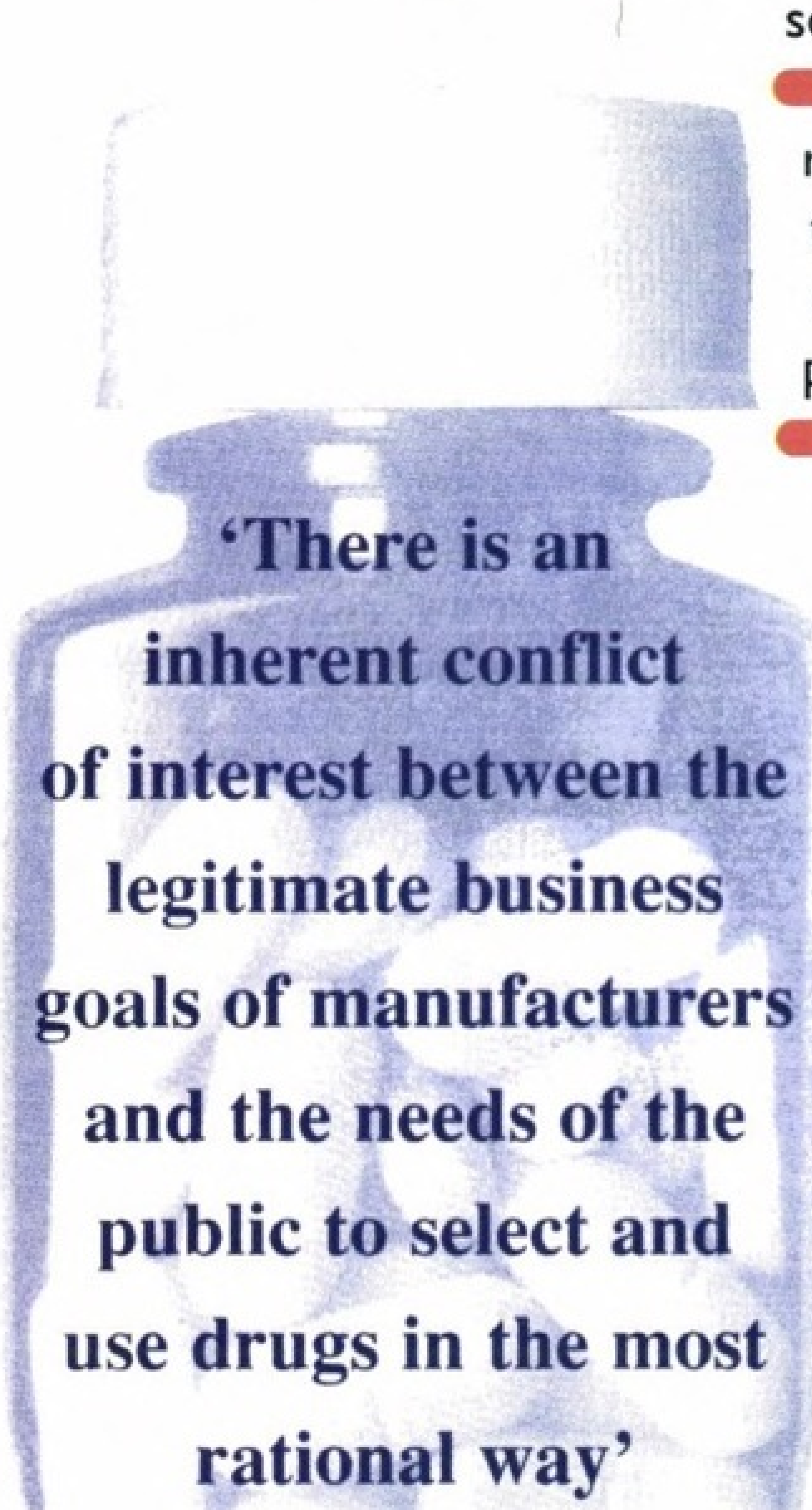
Women

Women are a major target for drug companies, who encourage doctors to prescribe drugs – like tranquillizers or antidepressants – for problems which may be related more to women's status in society than to any actual illnesses.

In India the company Sandoz recommends giving women with anxiety thioridazine, an antipsychotic drug usually reserved for the treatment of severe psychoses such as schizophrenia.

In the West, hormone replacement therapy treatments for menopausal women have been the biggest growth area: 30 per cent of post-menopausal women in the US and 10 per cent in Australia and Britain consume powerful hormones associated with an increased risk of some forms of cancer.[10] The concept of hormone replacement is itself promotional. The hormones are not missing: they do not need to be replaced.

Women in the Majority World are the target for invasive and dangerous contraceptive treatments.



> 'There is an inherent conflict of interest between the legitimate business goals of manufacturers and the needs of the public to select and use drugs in the most rational way'
>
> World Health Organization, 1993

Children

Children have frequent but not usually serious illnesses which are part of a natural process that helps build up immunity. For many of these a wide range of drugs is not required. According to the WHO, two-thirds of all drugs used by children may be of little or no value.[11]

From Peru, Pakistan and the Philippines come reports of claims by vitamin and tonic manufacturers that their products improve children's intelligence. No such drugs exist.

In Brazil, a 1992 study of some 6,000 children aged three to four years found that nearly 60 per cent had used one or more drugs in the previous two weeks and nearly 10 per cent had been given medicine daily for a month or more. Loss of appetite was the main reason for the use of the medicines.[12]

In Malaysia and the Philippines pharmaceutical companies have used measures such as free samples, promotional toys and children's clubs to target children directly.

The rationale behind selling unnecessary drugs for children is to start a habit of a lifetime.

The Elderly

Health problems are highly prevalent among the elderly, with 80 per cent having one or more chronic condition. But often these problems are only compounded by overprescription of drugs and by doctors relying solely on manufacturer's claims. Old people metabolize drugs differently and problems as diverse as incontinence and dementia can sometimes be drug-related.

In the US one out of every six people is over 60. But they consume one out of every two sleeping pills, two out of every three antihypertensives, one out of every three antidepressants and two out of every five gastrointestinal drugs.

The future: marketing disease and self-medication

There is a growing trend worldwide to shift the payment for medicine from state to consumer, by encouraging more self-medication. This means moving more products from prescription-only to over-the-counter classifications. In many countries of the South, prescription-only drugs are often freely available.

In 1992 the world market for over-the-counter medicines was estimated at $30.4 billion. By 2002 the figure is expected to climb to $43.4 billion (at constant dollars).[13]

Andrew Chetley has researched and published widely on health issues. *Problem Drugs* (Zed Books, London 1995), his latest book, is an extensive study of misused medicine.

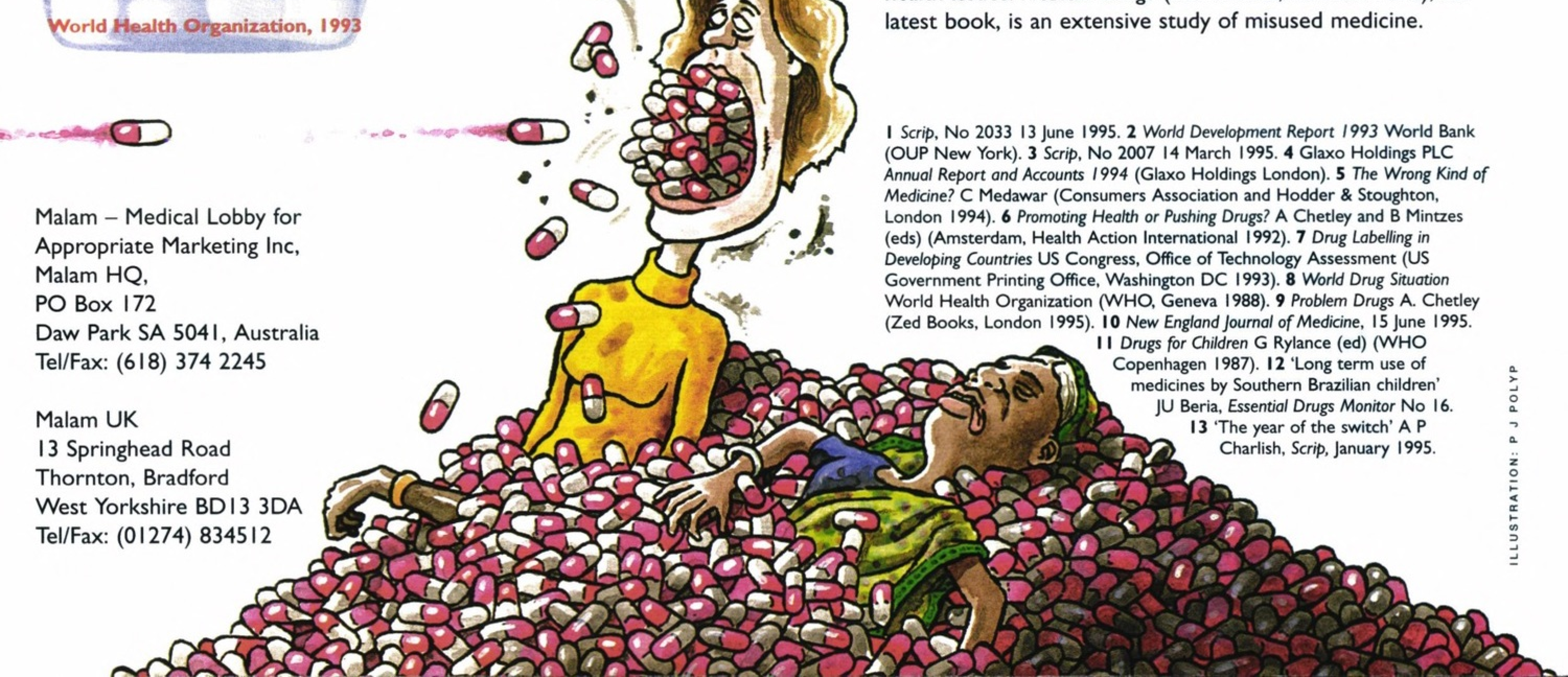


ILLUSTRATION: P J POLYP

Malam – Medical Lobby for
Appropriate Marketing Inc,
Malam HQ,
PO Box 172
Daw Park SA 5041, Australia
Tel/Fax: (618) 374 2245

Malam UK
13 Springhead Road
Thornton, Bradford
West Yorkshire BD13 3DA
Tel/Fax: (01274) 834512

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1 *Scrip*, No 2033 13 June 1995. **2** *World Development Report 1993* World Bank (OUP New York). **3** *Scrip*, No 2007 14 March 1995. **4** Glaxo Holdings PLC *Annual Report and Accounts 1994* (Glaxo Holdings London). **5** *The Wrong Kind of Medicine?* C Medawar (Consumers Association and Hodder & Stoughton, London 1994). **6** *Promoting Health or Pushing Drugs?* A Chetley and B Mintzes (eds) (Amsterdam, Health Action International 1992). **7** *Drug Labelling in Developing Countries* US Congress, Office of Technology Assessment (US Government Printing Office, Washington DC 1993). **8** *World Drug Situation* World Health Organization (WHO, Geneva 1988). **9** *Problem Drugs* A. Chetley (Zed Books, London 1995). **10** *New England Journal of Medicine*, 15 June 1995. **11** *Drugs for Children* G Rylance (ed) (WHO Copenhagen 1987). **12** 'Long term use of medicines by Southern Brazilian children' JU Beria, *Essential Drugs Monitor* No 16. **13** 'The year of the switch' A P Charlish, *Scrip*, January 1995.

Child of grace: having a baby can depend on money and rivalry.

Midwife in the middle

On call 24 hours a day at a maternity clinic in a Ghanaian village, Alice Oppong (left) is a busy woman. She found time to talk to **Ajoa Yeboah-Afari.**

TOP: MARION KAPLAN / CAMERA PRESS; RIGHT: AJOA YEBOAH-AFARI

IT IS A QUIET SATURDAY morning at the maternity section of the Prampram Kotoka Health Post. Prampram – population about 8,000 – is a small fishing town on the Atlantic coast in the Greater Accra Region of the West African country of Ghana.

Sheep are grazing in the Outpatients Hall, which is empty except for a couple of women who sit chatting on one of the wooden benches. Neither of the women shows any sign of pregnancy so they must be relatives come to visit, if the unmistakable crying of a new-born baby from inside the building is anything to go by.

A visitor who asks for the midwife is told she's just popped home but is expected soon. Minutes later she bustles in, all smiles and apologies, and goes to check on the new mother, who has been delivered of a baby girl at dawn. Since this is a Saturday the baby's 'day' name will be Ama. In almost every part of Ghana there are female and male names for children for each day of the week, to which other names and a surname are later added.

The midwife, Alice Oppong, invites the visitor into her small consulting room to talk about her work. She has been a midwife for five years, and was transferred to Prampram only six months ago. Her husband and three children living in the nearby harbour town of Tema cannot move to Prampram – instead, they visit every weekend. She can't go to see them because at present she is the only midwife at the health post, and so is on call 24 hours a day. There should be at least two midwives, even three, but unfortunately the others are on sick leave. She originally trained as an Enrolled Nurse, but after working for 15 years she was eligible to apply to train as a midwife. 'With my background it means I'm able to lend a hand at the clinic when necessary.'

Blessed with electricity

Although Prampram is only an hour's drive from the capital Accra, and blessed with electricity, it is still a rural community with its share of rural problems. Two of these are poverty and a high birth rate – which are also national problems. Ghana's population is currently estimated at 17 million, of which some 70 per cent is rural. Official sources put the population growth rate at 2.6 per cent, but other sources believe it is over 3 per cent, with the highest rates in the villages.

'They really like having babies here,' Oppong says, 'which means a lot of work for me. But I don't mind because that's the best way for me to get more experience.' Sometimes there are three or four births a day – this includes patients from the surrounding villages which make up the 17,000 population of the Prampram health district. She has no explanation as to why so many babies are born in Prampram, but considers unemployment to be quite important.

Few of the women have sources of income other than being dependent on a man. 'It's basically a fishing community,' continues Oppong. 'In the past education was not a priority. Thus they marry at an early age and start having children immediately. Also, the incidence of divorce is high and the women habitually have children as soon as they enter a new relationship.' Perhaps this reflects the women's strategy of 'cementing' a new relationship to guarantee the man's financial support. Oppong adds that in some polygamous marriages there is rivalry between wives to see who can bear more children for the husband.

In her view the traditional birth ceremonies and practices also serve as an incentive. According to local custom, two weeks after the birth the baby is 'outdoored', brought outside for the naming ceremony. This is when the husband gives his wife presents – including, in some cases, a substantial sum of money – to show his love. The ceremony is sometimes given a touch of carnival, the family processing through the town with the husband's gifts on proud display. The flip-side is that this is usually the last time the wife will receive any significant sum of money from her partner, until she has another baby.

Oppong says it's not strange to find a 25-year-old woman with six children, particularly among those who are illiterate. Only educated women tend to come for family-planning advice and service. 'However, we're doing our best. The Community Health Nurses also visit people at home and talk to them about it. We tell them that even if they don't want to stop having more children, they should consult us on how to space births.'

A woman brings a week-old baby with an infected umbilical cord. Oppong explains, as she applies medication, that new mothers are given medication for dressing the cord when they're discharged, and normally the cord stump falls off within two weeks. However, because of their anxiety to ensure that it will fall off and heal before the all-important 'outdooring' ceremony, the women apply their own herbal preparations, or a home-made salt solution, which often leads to infection.

There's the sound of laughter outside, shouts; a voice calling the midwife. She goes out and returns followed by a very pregnant, sheepish-looking middle-aged woman in a shapeless outfit – obviously charity clothing from Europe. 'Kwaale,' Oppong says to her (this is not her real name), 'go and lie on the bed and I'll check how the baby is doing. You were trying to avoid me but God has shown you up. I've told you that you won't be asked to pay any money, so why are you running away from me?' Kwaale had been stealthily walking past the clinic when she was noticed by someone who knew that the midwife had been looking out for her. 'This should be your last delivery, Kwaale, you're not strong enough to have another baby.'

Kwaale agrees. 'I feel so tired, I'm tired all the time, and when I walk my heart pounds so.' She has borne eleven children but only five have survived. There's a Safe Motherhood programme in place in Ghana which seeks to reduce child- and maternal-mortality rates by half. Every year the Ministry of Health organizes nationwide campaigns to vaccinate children against childhood diseases.

Kwaale is given some tablets. After telling her the dosage Oppong makes some marks on the envelope with a pen to help her remember: two vertical lines, a dash and two more lines mean two tablets twice a day.

The standard charge for delivering at the health post is 2,200 Ghana *cedis* (about two US dollars). Generally the patients pay, even if some of them have to wait until their men return from their fishing trips. There are a few like Kwaale who simply cannot pay, even though they continue to have children by 'invisible' men. Oppong says she has no information at all about Kwaale's husband. 'Such people have to be given free treatment to ensure a safe delivery, because if they have a difficult labour the problem will land on my doorstep just the same.'

What does she do in her spare time? She laughs. 'I have no spare time; I have to be on call all the time.'

But the standard fee applies only to normal delivery. If extra treatment is required, patients pay extra. 'And sometimes we don't have all the drugs they need,' says Oppong, 'so we give them prescriptions and they go to the nearest big town to buy the medicine'.

Intimidated

Serious cases are referred to the Tema General Hospital. But Prampram patients hate going to Tema since they feel intimidated there, not to mention the expense of hiring a taxi for about 5,000 *cedis*. 'They usually insist I should do my best to treat them here,' says Oppong. The clinic once had a vehicle, supplied by the ministry, but it has been broken down for months. 'Lack of transport is one of the biggest problems we face,' she says.

What does she do in her spare time? She laughs. 'I have no spare time; I have to be on call all the time. When I get some breathing space I rush home to do my household chores...' Does she enjoy her work? She smiles. 'Oh yes; I'm happy. In any case I don't think I can learn something else now; I can't go back to school!'

At this point one of the women comes to tell her that the new mother is feeling cold. Before she can go inside a young woman comes for ante-natal advice, but minus her clinic card which she has forgotten, and has to be helped to remember her last visit... The visitor decides that it is time to go. ■

Ajoa Yeboah-Afari is a freelance journalist based in Accra. A former Deputy Editor of the Ghanaian national weekly, *The Mirror*, she reports, among others, for the BBC African Service and West Africa magazine.

FESTIVAL OF HEALTH

On this floor you'll find the main primary health care Systems...
...There are many others which are less all-embracing. Some of these can be found on the second floor.
Got an infection? We can Zap it. Need surgery? Nooo problem. Any emergency, just come to us.
£5
Watch out for huge pres-criptions, side effects, unnecessary surgery, for that extra buck. Sometimes the treatment can cause more problems than it solves.
A complete guide to spiritual and physical health. Give us your insomnia, your back pain, your bronchitis-anything chronic -and see what we do. Tropical diseases our speciality.
There's nothing we can't help. If your doctor has given up on your arthritis, asthma or some other chronic problem - give acupuncture a shot and get your body going.
I'd rather go to hospital in an emergency. And all that energy flowing about with acupuncture is not a good idea for infections or people with cancer.
Watch out for wild claims. And find someone you trust-doctors mak their own brews.

INFORMATION

Healing should be a two-way process between practitioner and client – any therapy which encourages your involvement will bring more satisfying results.

WHEN CHOOSING A PRACTITIONER **DO** ◆ check qualifications, training and time spent in practice ◆ check whether the practitioner is registered with a recognized organization which has a complaints and disciplinary procedure ◆ try to ascertain that the therapy is safe, plausible and appropriate ◆ check their attitude to other forms of medicine ◆ ask for an estimate of length of treatment and costs.

DON'T GO TO ANYONE ◆ who makes miraculous claims ◆ who suggests you give up consulting a conventional doctor ◆ who doesn't involve you in drawing up your treatment programme ◆ with whom you are uncomfortable.

ALLOPATHIC MEDICINE

The main brand of medicine in the West, gradually replacing other kinds of medicine in countries of the South. Often referred to as 'conventional medicine', even though it became scientific only in the twentieth century. The majority of medical drugs and treatments in use today have been developed over the past 30 years.

DIAGNOSIS Based entirely on symptoms, zeroing-in on trouble spots. Has an arsenal of machinery. Doctors are mainly interested in clients' medical histories rather than their wider lives. Usually has the shortest consultations and the highest cost of all primary-care options.

ACUPUNCTURE & TRADITIONAL CHINESE MEDICINE

Developed over 4,000 years, holistic Chinese medical theory grew along with Taoism – which sees individuals as a microcosm of the universe. Apart from acupuncture, treatments include herbal medicines (using over 4,000 different herbs), food therapy, exercise (such as T'ai Chi Ch'uan) and massage.

DIAGNOSIS Depletion of *chi* (life force or energy) by excess and intemperance is responsible for imbalance and disease. *Chi* circulates in the body through invisible channels beneath the skin, along which are the 2,000 or so known 'acupoints' stimulated by acupuncture to release blockages and replenish energy. Assessment is very detailed, based on observation, listening, smelling, asking questions and reading the pulse at six different points.

AYURVEDA

Ayurveda, the Sanskrit 'Science of Life', is an ancient Indian school of medicine which includes psychological, cultural, religious and philosophical concerns. Like Chinese medicine it seeks to balance the body's energies.

DIAGNOSIS Ayurveda focuses on removing the causes of disease rather than treating symptoms. It restores balance through herbal remedies, cleansing routines, yoga, meditation and diet. Nothing of importance to the client's well-being is omitted – from relationships to the astrological chart, age, mood, time of day and climate.

Information sources: *The Encyclopaedia of Alternative Health Care* by Kristin Olsen, (Piatkus, London 1992); *Health Education Authority Guide to Complementary Medicine and Therapies* by Anne Woodham (HEA, London 1994).

Any reversible disorder- watch us reverse it! Our medicines do no harm. You can consult other practitioners as well, if you want to.
Things usually get worse before they get better-for the body to fight disease, they say. In an emergency I'd go conventional. Visit an Osteopath for muscle and joint complaints.
We don't just cure disease, we balance your entire body. Change your lifestyle and live better.
LIFE BEGINS TODAY
They send you off to a conventional doctor if you've got anything really acute. And all that fasting and detox needs superhuman willpower.
FESTIVAL OF HEALTH
SECOND FLOOR

HOMEOPATHY

Founded in the eighteenth century by Samuel Hahnemann, a German physician disenchanted with the crude medical practices of his time. Stimulates the body to use its own healing resources to fight illness. Medicines are incredibly diluted forms of naturally occurring substances. If taken in larger quantities they would cause similar symptoms to the ones they are deployed against.

DIAGNOSIS Homeopaths see symptoms as indications of a disease pattern, not the disease itself. Consultations involve the practitioner selecting the right remedy tailored to match the client's constitution, after taking a detailed personal history.

THE ALEXANDER TECHNIQUE
AROMA THERAPY
BACH FLOWER REMEDIES
THE BATES METHOD
BIORHYTHMS
CHIROPRACTIC & OSTEOPATHY
COLON HYDROTHERAPY
COLOUR THERAPY
DANCE MOVEMENT THERAPY
HEALING
HYDROTHERAPY
HYPNOTHERAPY
IRIDOLOGY
PSYCHOTHERAPY
REFLEXOLOGY
REIKI
ROLFING
SHAMANIC MEDICINE
SHIATSU
VOICE THERAPY

NATUROPATHIC MEDICINE

Naturopaths combine insights from other holistic systems such as Ayurveda and Chinese medicine with conventional medical training. Remedies, if used at all, are herbal and the main emphasis is on regulation of diet.

DIAGNOSIS Naturopaths act more as teachers than doctors helping clients to learn how their bodies can heal themselves. Consultations combine building a holistic profile with a routine medical examination. Irises may be examined and blood, hair and sweat tested for toxins. Treatment involves changing aspects of lifestyle that have caused imbalance.

EXIT

Don't be a passive pill-popper. Combine your own knowledge about yourself with that of the therapist you choose.

ILLUSTRATION: JIM NEEDLE

How the ideal of 'health for all' was turned into the reality of worsening health for the world's poor.

David Werner asks...

Who killed Primary Healthcare?

BOLSTAD / PANOS PICTURES

AN INSTRUCTOR of community-health workers in Kenya once told me about a sobering experience she had when she was visiting a rural health post. In the heat of midday an exhausted young mother arrived on foot from an isolated hut several kilometres away in the savannah. In a colourful shawl across her back she carried her baby, Kofi, who – she explained – had severe 'running stomach' and was very ill. She begged the health worker for the life-saving medicine in the silver envelope that she had heard about on the radio. She was referring to Oral Rehydration Salts, of which 400 million packets are produced each year as part of the international campaign to reduce deaths from diarrhoea, still the biggest killer of children in many poor countries.

Lovingly the mother lifted little Kofi from the shawl then gave a sudden cry of despair. Kofi was dead. His wrinkled little body made it clear that he had died of dehydration. The long trip in the hot sun had been too much for him.

'I felt partly responsible,' sighed the instructor. 'If we had only taught mothers to make a home-made rehydration drink instead of teaching them that they needed a "magic packet with a silver lining", her baby might still be alive today. But we listened to the experts in Geneva and Washington.'

As a stop-gap measure for undernourished children Oral Rehydration Therapy (ORT) should certainly be given high priority. But it must be introduced in ways that foster self-determination, not dependency. On my travels to the villages of Africa, Asia and South America I have heard many similar stories of acclaimed technological solutions that have not lived up to their promises.

Primary Healthcare (PHC) as originally outlined by the world's nations at the 1978 Alma Ata Conference did indeed seek to establish the accountability of health workers and health ministries, with guarantees to meet the basic needs – including food needs – of everyone. This commitment was based on the success of community-based health programmes that had sprung up in the Philippines, Guatemala, India and elsewhere. The barefoot doctors of revolutionary China had demonstrated that with political will for equity a state could achieve good health at low cost.[1]

Unhappily, the high expectations of Alma Ata have not been met. Three major changes have sabotaged them.

Selective Primary Healthcare

No sooner had the dust settled after the Alma Ata Conference than top-ranking health experts in the North began to trim the wings of Primary Healthcare. With global recession and shrinking health budgets they felt that such a comprehensive approach would be too costly. If health statistics were to be improved, they argued, high-risk groups must be 'targeted' with a few cost-effective interventions. This politically sanitized version was dubbed Selective Primary Healthcare.

UNICEF, which had been a strong advocate of the comprehensive original, now took the line that Selective PHC was more 'realistic'. Through its so-called Child Survival Revolution' (which some critics called a counter-revolution) UNICEF narrowed the focus to growth monitoring, ORT, breastfeeding and immunization. In most countries it was narrowed even further to the 'twin engines of child survival', ORT and immunization.

The global Child Survival Campaign

TAYACAN / PANOS PICTURES

Hilary Clinton beams: but dissent was the most interesting thing about the Social Summit in Copenhagen (above).

quickly won high-level support. For those in positions of privilege and power it was safe and politically useful. It promised to improve a widely accepted health indicator – child mortality – while skirting in all but rhetoric the social and economic inequities underlying poor health. Many health professionals and governments jumped on the bandwagon. Even the World Bank began to lend its support.

But technological solutions can only go so far. Over 133 million children still die each year, roughly the same number as 15 years ago, even if this represents a smaller percentage of an increased child population. Most of these deaths are still related to poverty and undernutrition.

Reducing child mortality through selected technological interventions does not necessarily improve children's health or quality of life. During the 1980s a disturbing pattern emerged in some poor countries: while child-mortality rates dropped, undernutrition and morbidity rates increased. The pattern was ominous. Sure enough, during the late 1980s and early 1990s, in many countries the decline in child mortality slowed or halted. While in some countries – especially in sub-Saharan Africa – child deaths began to increase.[2]

Even the 'twin engines' of child survival proved difficult to sustain. Immunization rates began to decline, with a corresponding increase in polio cases. Egypt's oral-rehydration program, which has been upheld as a success story, saw usage rates for oral rehydration salts in the 1990s plunge from more than 50 per cent down to 23 per cent.[2] Salts packets were originally given to mothers free. Their provision was then commercialized. Now poor families are brainwashed into spending food money on these products rather than using potentially more effective, less expensive, home-made cereal drinks. A 'simple solution' for child survival became yet another way of exploiting the poor.

Structural Adjustment Programmes

The next big assault on Primary Healthcare was the introduction during the 1980s of Structural Adjustment Programmes (SAPs). Engineered by the World Bank and IMF, these austerity policies invariably hit the poor hardest. Public hospitals and health centres were sold to the private sector, pricing their services out of the reach of the poor.

> ***In Kenya the introduction of fees at a centre for sexually transmitted diseases caused a sharp decline in attendance***

'User-financing' and 'cost-recovery schemes' are among the most pernicious of these policies. The poorest families tend to get sick most often and so pay the most. They are often willing to spend their last pennies to care for their sick children. But they can ill afford to do so. In the Makapawa community-based health programme in the Philippines, health workers found that the money poor families spent on medicines instead of food contributed to child undernutrition and high mortality. By making remedies for common problems at home they spent less on pills, more on food, and their children's health improved.

Studies in some countries have shown that when cost-recovery was introduced the use of health centres by high-risk groups dropped. In Kenya the introduction of fees at a centre for sexually transmitted diseases caused a sharp decline in attendance and an increase in untreated infections.[3] In China user fees for tuberculosis treatment led to millions more cases of infection.

'Investing in Health'

The third assault on Primary Healthcare came with the World Bank's 1993 *World Development Report*, 'Investing in Health'. A better title might have been 'Turning Health into an Investment'. For when stripped of its humanitarian rhetoric its chilling thesis is that the purpose of keeping people healthy is to promote economic growth.[4] If such economic growth were intended to serve the well-being of all then the Bank's intrusion into healthcare might be more palatable. But the 'economic growth' which the Bank promotes has invariably benefited large multinational corporations, often at devastating human and environmental cost.

On first reading, the Bank's strategy looks comprehensive, even modestly progressive. It acknowledges the economic roots of ill health, and that improvements are likely to result primarily from advances in non-health sectors. It calls for increased family income, better education (especially for girls), greater access to healthcare, and a focus on basic health services rather than specialist care. It quite rightly criticizes the persistent inequity and inefficiency of current Third World health systems. Ironically, in view of its track record of slashing health budgets, the Bank even calls for increased health spending.... So far so good.

But, on reading further, we discover that the key recommendations spring from the same paradigm that has worsened poverty and health levels. To save 'millions of lives and billions of dollars' governments must adopt 'a three-pronged policy approach of health reform':

- 'Foster an enabling environment for households to improve health' – which really means requiring disadvantaged families to cover the costs of their own healthcare.
- 'Improve government spending in health' – meaning trimming government spending from comprehensive coverage to a narrow selection of cost-effective measures.
- 'Promote diversity and competition in health services' – which means turning over to private, profit-making doctors and businesses most of those government services that used to provide free or

subsidized care for the poor.

One reviewer (David Legge) observes that the World Bank Report 'is about healthier poverty'.[5] It ignores the fact that in many countries with SAPs average per-capita income has plummeted. Even in countries whose economies have partially recovered, most gains have been pocketed by the wealthy.

The Bank's new policy for the Third World sounds dangerously like the health-care model of the US. It argues that private healthcare for individuals gives more choice and satisfaction and is more efficient. But there is little evidence to support this claim. The US health system, dominated by a profit-hungry private sector, is by far the most expensive in the world. Yet US health statistics are among the worst in the Northern industrialized nations. The city of Washington DC has higher child- and maternal-mortality rates than Jamaica.

Most children can survive without medicine, none without food

It is an ominous sign when a giant financial institution with such strong ties to big government and big business bullies its way into the health field. According to the British medical journal, *The Lancet*, the World Bank is now moving into first place as the global agency most influencing health policy, even ahead of the World Health Organization.[6]

Despite all its humane-sounding rhetoric, the central function of the World Bank remains the same: to draw the governments of weaker states into a global economy dominated by large, multinational corporations. Its loan programmes, development priorities and adjustment policies have deepened inequalities and added to the poverty, ill health and deteriorating living conditions of at least one billion human beings.

Mexican model

I have seen for myself how community action can turn the tables. Based in the mountains of western Mexico is Project Piaxtla, a villager-run health programme. Analysing the factors behind the high death rate of children from diarrhoea and undernutrition, the health team there saw that a key cause was share-cropping – poor, landless families must give up half their harvest to the rich landowner.

They realized that conventional health measures were not enough to improve the survival and quality of life of children. By organizing peasant invasions of illegal holdings they succeeded in redistributing over half of the best, riverside land. With irrigation they doubled the yield, giving poor farming families more to eat. Their children gained weight and succumbed less to common health problems. The death rate of under-fives dropped from 34 per cent to around 6 per cent.

In explaining the dramatic improvement people gave some credit to better healthcare but said the big difference was their joint struggle to win their constitutional land rights. Such an interpretation of health is consistent with the Alma Ata Declaration's insistence that health depends on equity. Most children can survive without medicine, none without food.

Unfortunately, in the 1990s the peasant farmers of Mexico are seeing the gains they made reversed. Mexico has an enormous foreign debt and in exchange for new loans has been subjected to stringent adjustment policies. Land-ownership is concentrating again into fewer hands – including those of US agribusiness transnationals. More than a million small farmers have lost their holdings and migrated to city slums, where unemployment soars.

The village health team in Mexico, along with thousands of concerned groups around the world, are coming to realize that new strategies – comprising local action with global solidarity – are needed to counter the transnational power structure. Although the obstacles are colossal, there are encouraging signs that such a groundswell is under way. The '50 Years is Enough' international coalition, which opposes the exploits of the World Bank and the IMF, is a good example. Many networks focusing on health are striving to increase public awareness and to organize pressure from below on the world's policy-making bodies. Two such grassroots coalitions based in the South are the Third World Network in Malaysia, and the International People's Health Council in Nicaragua.

At the recent Social Summit in Copenhagen nearly 1,000 non-government organizations and people's movements joined in protesting the official Declaration, calling for fairer distribution of resources and restructuring of the world order so that poor and disadvantaged people have a stronger say in decisions that determine their well-being.

In the final analysis, creating a healthier social order will depend on reaching across traditional barriers and replacing global pillage with a global village – where everyone's basic needs are equitably and flexibly met. ■

David Werner has written extensively on the politics of healthcare provision. He is the author of *Where there is no Doctor*, a seminal manual for healthworkers in the South. Currently he is on the board of Healthwrights based in Palo Alto, California.

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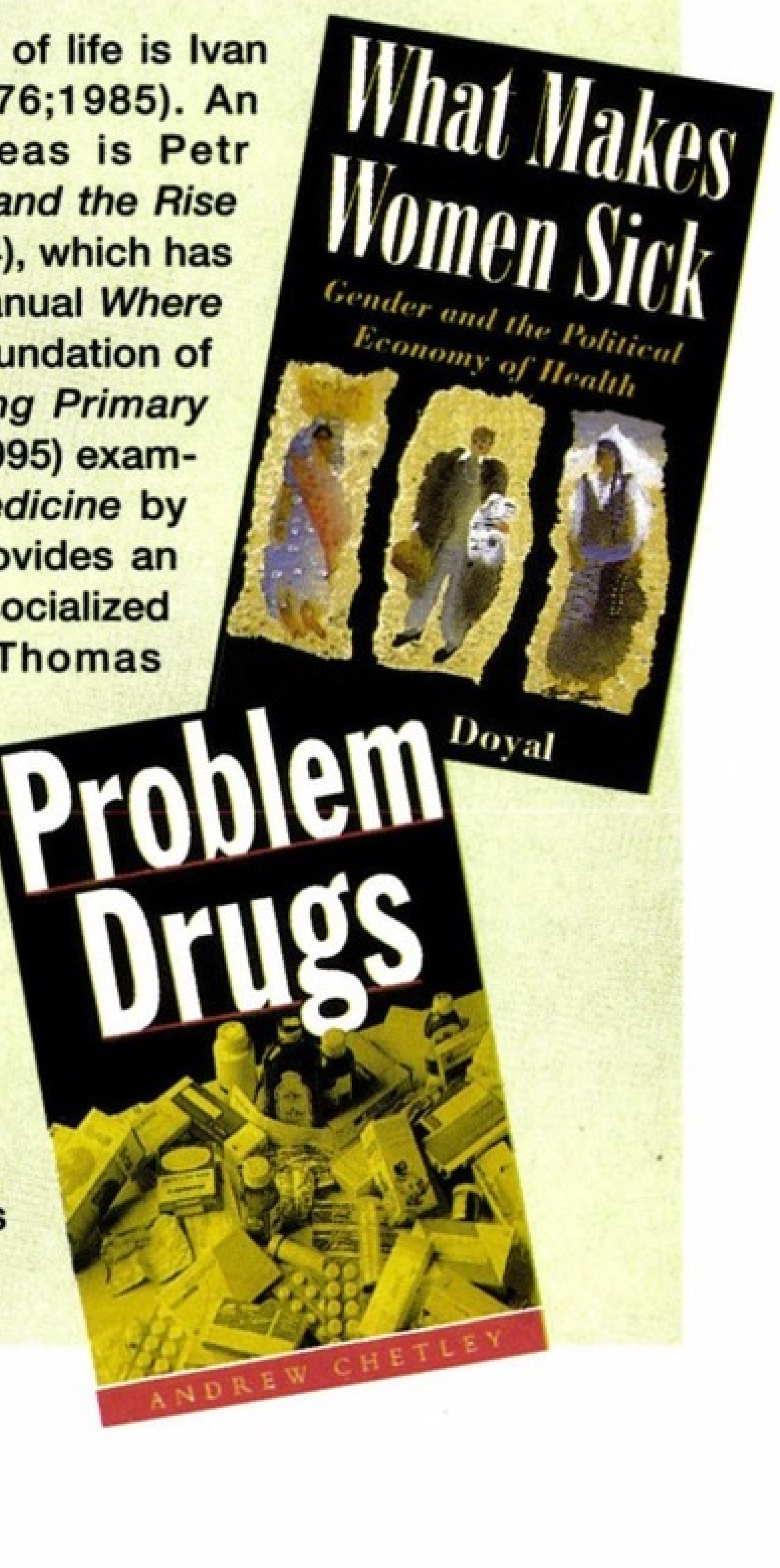
[1] *Good Health at Low Cost*, Scott B Halstead, Julia A Walsh and Kenneth S Warren, (Rockefeller Foundation, New York, 1985). [2] *State of the World's Children*, (UNICEF, 1994). [3] *The Lancet*, vol 340, 1992. [4] 'The World Bank, Health, and Africa', by M Epprecht in *Z Magazine*, November 1994. [5] *Investing in the Shaping of World Health Policy*, D Legge (workshop paper). [6] The Lancet, vol 342, 1993.

WORTH READING on...**MEDICINE**

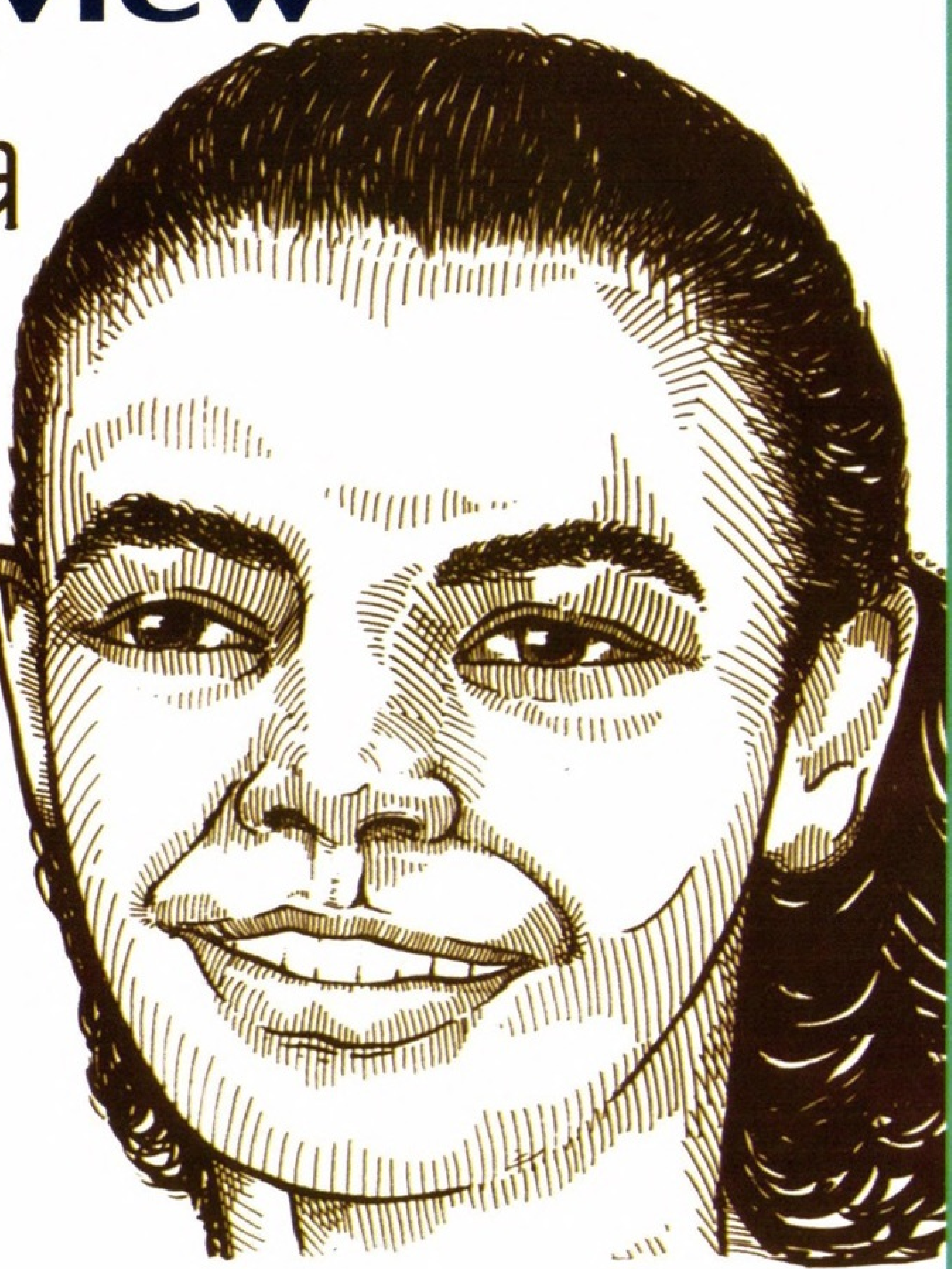
THE CLASSIC CHALLENGE to the medicalization of life is Ivan Illich's *Limits to Medicine* (Penguin Books, 1976;1985). An informed and polemical update of allied ideas is Petr Skrabanek's witty *The Death of Humane Medicine and the Rise of Coercive Healthism* (SAU, Bury St Edmunds, 1994), which has something to infuriate everyone. David Werner's manual *Where there is no Doctor* is published by the Hesperian Foundation of Palo Alto in a wide range of languages. *Sustaining Primary Health Care* by Anne LaFond (Earthscan, London, 1995) examines why more has not been achieved. *Strong Medicine* by Michael Rachlis (Harper Collins, Toronto, 1994) provides an unorthodox but convincing prescription for saving socialized medicine. *The Origins of Human Disease* by Thomas McKeown (Blackwell, Oxford and Cambridge, Mass. 1988;1994) is a manageable survey. Andrew Chetley's thoroughly researched *Problem Drugs* (HAI/Zed, London and New Jersey, 1995) is an excellent guide to what to avoid. Geoffrey Cannon's *Superbug*, (Virgin, London ,1995), examines the overuse of antibiotics and the rise of resistant germs. Among a number of books on women's health Lesley Doyal's *What Makes Women Sick: Gender and the Political Economy of Health* (Macmillan, London, 1995) is international in scope and eminently readable.



The NI Interview

Marina Silva

Tony Samphier talks to the woman who has emerged from a new generation of eco-conscious politicians in Brazil to be dubbed an 'Amazon legend'.



'When I fly over the Amazon by plane I love to look at the green carpet of forest, criss-crossed by rivers,' says Marina Silva, who took her seat in the Brazilian Senate last January after an unexpected election win in the Amazon state of Acre. The national daily *Jornal do Brasil* described it as a 'victory of the dream over circumstance'.

'I feel a great sense of pain when I see an area of deforestation,' she says. She fears that Amazonia will 'end up with the same devastation as in Europe and the United States'. But she is not interested in saving the forest for its own sake alone. From an early age she learned its value: people depend on it for food, work and pleasure. So her prescription relies as much on the sustainable use of its resources as on conservation.

A reference to her favourite meal underlines the point: 'I hope the ecologists will forgive me,' she says, 'but in the rubber-tapper settlement where I lived as a child, game was very important. I still haven't forgotten the flavour of a good *farofa de paca* (a large forest rodent, roasted with cassava).'

Whereas many political careers in Brazil are the product of wealth and privilege, Silva's rise to prominence stems from a struggle for life itself. 'My mother had 11 children, but 3 died when they were young,' she explains. 'Of the survivors I was the eldest. So from a young age I helped to look after my six sisters and one brother.'

There was no school where her family lived. Silva worked in the fields and in extracting rubber until she was 16. She suffered hunger, sometimes going without food for 24 hours at a time. At 14 she was still illiterate. A year later her mother died. 'I had to acquire some knowledge to help my father,' she says. 'Simple mathematics at first, in order to calculate the weight of rubber.'

They say I'm a fighter. I agree, but I think that, in myself, the fight comes after the dream

The experience whetted Silva's appetite for education. Then, at 16, she contracted hepatitis. Ironically this helped her to realize her dream. 'I was unable to do the heavy rubber-tapping work,' she says. 'I asked my father if I could move to the city because I wanted to study.' In just three years she completed and passed all the necessary exams to enter university.

When rubber-tappers' union president Chico Mendes helped found the Workers Party (PT) and decided to be an election candidate in Acre she joined him. They worked together in the trade-union movement and set up a congress in Acre. His assassination in 1988 was a personal tragedy for her.

'We had many years of companionship which cannot be easily summarized,' says Silva. 'But what I have clearest in my mind is Chico himself – his way of being, his style of leadership. He knew how to listen and let everyone else speak, and only later would he make up his own mind. This is a very important lesson he left me.'

I have great admiration for people who struggle in the way Gandhi did: at once activist and pacifist

For both of them the biggest test came with the *empates*, the human-barrier campaigns against tree-felling which saved thousands of hectares of forest. 'I remember them with great emotion,' she says, 'especially those organized by Chico Mendes in the Cachoeira rubber-tapper settlement'.

Though trade unionists and environmentalists are often the target of intimidation and violence in Brazil, non-violence is an important part of Silva's political armour: 'I have a great admiration for people who struggle in the way Gandhi did: at once activist and pacifist.' As a local councillor in Rio Branco, the capital of Acre, she had to fight tooth and nail to get local conservatives to declare an official day of remembrance for Mendes. In the end she won.

'They say I am a fighter,' she says. 'I agree, but I think that, in myself, the fight comes after the dream.'

Her current political success reflects the way environmental and social activists of her generation in Brazil have chosen to fight within the PT rather than the small Green Party. In their view the Greens deal with parks and flowers while the PT grapples with the socio-environmental crisis.

'I identify with people who want a party of proposals, of dialogue with other parties and with civil society,' says Silva – a coded message that she has moved away from the far-left politics of her youth. 'The PT was the logical option,' she concludes.

Today, already described as an 'Amazon legend' by the Brazilian press, Silva is a force to be reckoned with in the battle for the life and soul of the Amazon – the slash-and-burn developers and big landowners versus those who need the forest for their survival. ■

Tony Samphier is freelance journalist.
This interview is courtesy of **Gemini News**

Reviews

music

New Moon
by **Abdelli**
(Virgin /Real World CDRU 54)

Brian Jones presents the Pipes of Pan at Jajouka
by **Master Musicians of Jajouka**
(Philips Classics/Point 446 487)

North African Berber culture has a reputation for being insular, using its remote geographical location as a counterbalance to the dominance and pervasiveness of Arab culture. These two records are, in different ways, strongly Berber. Both present singular ways of transmitting tradition. Singer and *mandola* player Abderrahmane Abdelli is a Kabyl Berber from Algeria. He uses his own language and much of his native modalities. The twist comes from his range: Spanish influences abound while some passages of wild gypsy violin sound as though they come straight out of Central Europe.

New Moon, Abdelli's first album release on a major label, is a richly rewarding experience. Its overall pace is slowly sinuous. There is nothing of the fanaticism that marks Algeria's popular *rai*, or indeed, the ritual dances of the Master Musicians of Jajouka. Instead, his ten songs seem to weave back and forth, using traditional instrumentation aligned with Western production to produce a sultry, airy effect. The focus is always on the curve of Abdelli's voice. His themes are often oblique; songs that may be about aspects of human life are often linked to something much larger.

Politics ☆☆☆☆
Entertainment ☆☆

For those more interested in the unalloyed music of the Berbers, the **Pipes of Pan at Jajouka** is the real stuff. Long unavailable, this album's reedy shawn-like *raitas*, wailing women and scattered pulsating drum-rhythms have an eerie power. Originally released in 1971, the recording began life when the Rolling Stones' late guitarist Brian Jones was taken by painter Brion Gysin to Jajouka, a village in the Moroccan Rif mountains.

Jones – like other Jajouka *aficionados* such as William Burroughs and Paul Bowles – had his own agenda with Moroccan music. No strangers to drug-induced experiences, the foreigners were captivated by the idea that music itself could cause trances or transgress boundaries. In Jajouka, they found a culture hermetically sealed off from the outside world because of the Rif's inhospitable geography and the legendary 'wildness' of the Berbers. The music of the album comes from the village's celebration of the festival of Aid el Kebir, an occasion that links with a pagan past. At this festival the traditional deity Rou Jeloud – like the Greek god, Pan – would be represented by a figure decked out in goatskins. He was a supernatural presence invoked by the spirit of the music. Something of the fear and excitement that this incarnation must have provoked is captured in the wailing pipes of the Master Musicians. These are not the sanitized dances recorded for the masses, but something altogether stronger.

Brian Jones
presents
The Pipes of Pan at
Jajouka

Politics ☆☆☆☆
Entertainment ☆☆☆☆ **LG**

film

Land and Freedom
directed by **Ken Loach**

This film is an impassioned essay that reflects on a crucial moment in the twentieth century when people throughout Europe and the US gathered together in Spain to participate in the fight against fascism. The Spanish Civil War was called 'the last great crusade' – with the country becoming a battleground for the conflicting ideologies of the era.

Symbolically recovering the past, the film commences in the present in a Liverpool council housing estate where a young woman is trawling through the belongings of David, her grandfather who has just died. She finds letters and photographs which point to a history about which he had always kept quiet. Loach uses the familiar device to slip the audience back in time to find the young David, unemployed and disillusioned with life in Britain during the Depression. Loach's hero is typical of those who made the journey to Spain, eager and entranced by the possibilities of fighting for a belief but not quite comprehending what it might entail. In this respect he is the perfect protagonist, with the audience just behind him as he gradually comes to understand what is going on around him.

Ian Hart's portrayal of David is beautifully controlled. We see him transform from wide-eyed to wise as he joins up with a small militia group, develops friendships with his comrades, even embarking on an affair with a fellow soldier, Blanca – this is a war in which women fought.

Listening to the discussions, he also begins to comprehend the differences between the radical POUM revolutionaries and the more moderate Communist Party. Loach does not skim over the intricacies and for some the debates might seem hard to take. But those who long for the vigour of political cinema will not be disappointed by **Land and Freedom**: it's inspirational stuff.

Politics ☆☆☆
Entertainment ☆☆☆☆

Battleground of ideologies: the rigour of political cinema.

THE **CLASSIC**

books

The Chicago Gangster Theory of Life: Nature's Debt to Society

by **Andrew Ross**
(Verso, ISBN 0 8609-429-1)

Woody Allen once asked: Is there a body-soul split, and if so, which of them is it better to have? Substitute a nature-society split, and up pops the gangster.

With humour and irony Andrew Ross offers a sharp challenge to the new world order being offered by geneticists which, he says, equates to biological determinism or 'the Chicago gangster theory of life'.

But he also questions the zealous austerity of much environmentalist thought. Put simply, he doesn't want the Green movement to be seen as one which always says 'no'.

'In some neo-Puritan quarters a liberal society is seen as a primary cause of the ecological crisis. Asceticism, self-denial and guilt are the order of the day,' according to Ross. The structural poverty and hunger that has accompanied post-colonial under-development is not the result of natural scarcity but of bad economics. The hardest hit are the lower-income groups the world over who are being disciplined with 'the politics of scarcity and budgetary restraint'.

We must get rid of the concept of scarcity if we are to make a world in which hunger and poverty no longer prevail, Ross argues. That will mean changing pricing policies to take account of the regularly disguised social and environmental costs of production.

Finally, Ross warns of the dangers of surrendering too many rights to 'the voice of nature'. There are, he says, 'too many ventriloquists around who will speak in its name'. We ought to dialogue with nature – but not treat it as our supreme court.

Politics ☆☆☆
Entertainment ☆☆☆ **GF**

Reviewers: Louise Gray, George Fisher, Lizzie Francke.

STAR RATING

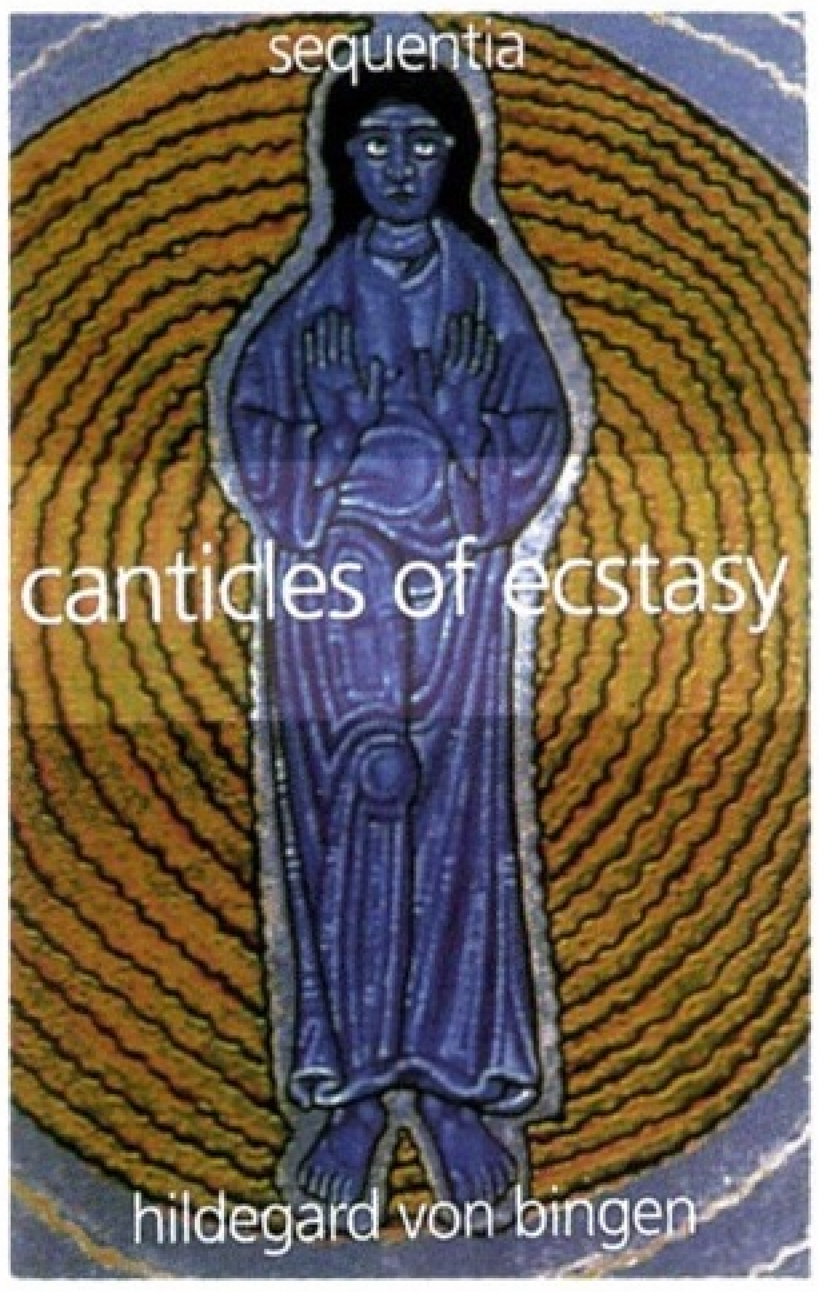
Excellent	☆☆☆☆☆
Very good	☆☆☆☆
Good	☆☆☆
Fair	☆☆
Poor	☆

Reviews editor: **Vanessa Baird**

Canticles of Ecstasy: Hildegard von Bingen

...being the music that brings heaven to earth.

CONTRARY TO POPULAR BELIEF, history is not made by Great Men. Behind the parade of kings, popes, barons, the dreary lists of dates and battles, stand the ranks of real people, seldom mentioned in history books but doing work of quality and, on occasion, genius. It comes as little surprise that the vast majority of those 'hidden from history' are women. Such a one was Hildegard of Bingen, a twelfth-century abbess who was, among other things an author, a composer, a scientist and a natural historian.



Born in 1098 to a moneyed family, Hildegard was at the age of eight walled into the Benedictine convent at Disibodenberg where she lived with the abbess, her aunt Jutta. Always a sickly child, Hildegard began to have what we today would probably call fits or epileptic seizures but which were then understood as visions and intense spiritual revelations. She said: 'From my girlhood I felt in myself in a wonderful way the power of the mysteries of secret and wonderful visions.' Her reputation as a seer and dispenser of prophecies grew, leading to her popular name 'The Sibyl of the Rhine'. In 1136 Hildegard succeeded Jutta as abbess and in 1150 founded her own community at Bingen.

As Abbess at Bingen, her fame and creative power increased significantly and, far from the image of cloistered innocence, she proved to be an astute and nimble operator on the twelfth-century political scene.

Hildegard's curiosity and thirst for knowledge knew no bounds. She was omnivorous in her writing and thinking and delved in such varied fields as medicine, heredity and botany. She wrote poetry, biographies, cryptography, one of the earliest mystery plays and collated several encyclopediae. She was also a highly original thinker, developing a detailed cosmology and a new scientific theory concerning the effect of the elements on the 'humours' of the body. Such studies allowed her a place at the centre of twelfth-century intellectual as well as spiritual life. At the time of her death in 1179 – at the age of 81 – she was widely respected and there were many calls for her to be canonized.

Despite all this it is doubtful whether we would recall the name of Hildegard today were it not for the music she composed for her fellow sisters. Her pieces, which she called *symphoniae harmoniae celestium revalationum*, were in a form of Plainsong or Gregorian chant. There are several available recordings, including a groundbreaking compilation called *Feather on the Breath of God* which was released in the 1980s and features the sublime soprano of Emma Kirkby. More recently, Barbara Thornton's vocal ensemble Sequentia has embarked on a project to record all of Hildegard's musical compositions, culminating in 1998 in a celebration of the 900th anniversary of her birth.

Their latest recording, a selection of Hildegard's *symphoniae* is called **Canticles of Ecstasy**. The beauty and simplicity of this music is breathtaking. One does not need to be a devout Christian or even a believer to appreciate the soaring perfection of the unaccompanied female voice. And much of the text, although scriptural in origin, can be seen as a contemplative hymn of praise to the natural world and the joy of living.

Although it is right that Hildegard is today seen as a feminist icon, we must not turn a blind eye to her shortcomings. She was very much a woman of her time, cannily using the existing – male – power structures of church and state to build herself a position of real influence. She travelled widely and in her sermons she fulminated against what she saw as heresy and was at the forefront of the persecution of the sect of Cathars – who incidentally, practised equality of the sexes and had women priests.

Such reservations should not diminish our awe at the size and scope of Hildegard's achievements. It is nothing short of miraculous – in a secular sense – that a woman in a brutal and misogynist age, racked by illness and infirmity for much of the time and burdened with the organization and maintenance of her community, could fashion for herself a place of respect and security from which she could collect and originate such a treasure-chest of knowledge and could above all produce such precious and life-affirming music.

After 900 years, Hildegard remains as complex a figure and as fascinating to the modern world as she was to her contemporary, Odo of Paris, when he wrote to her in 1148: 'It is said that you are raised in heaven, that much is revealed to you, and that you bring forth great writings and discover new manners of song...' ■

Peter Whittaker

***Canticles of Ecstasy: Hildegard von Bingen** sung by Sequentia is available on Deutsche Harmonia Mundi CD/Cassette 05472 773204. **Feather on the Breath of God** is on Hyperion CD A66039.*

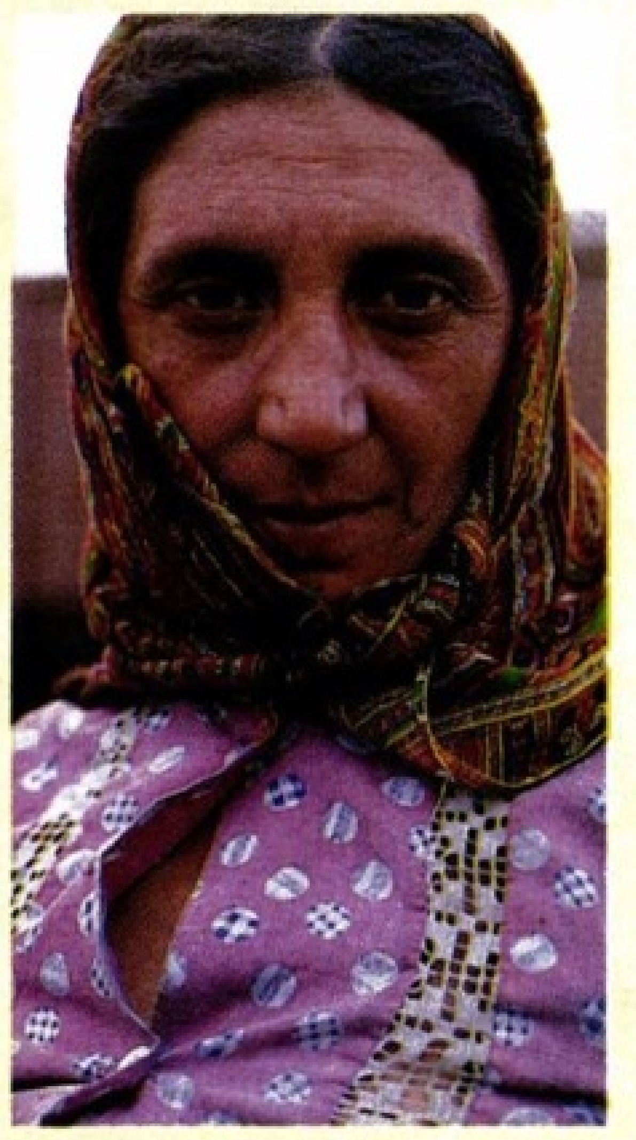
Curiosities

QUESTIONS THAT HAVE ALWAYS INTRIGUED YOU ABOUT THE WORLD WILL APPEAR IN THIS, YOUR SECTION, AND BE ANSWERED BY OTHER READERS. PLEASE ADDRESS YOUR ANSWERS AND QUESTIONS TO 'CURIOSITIES'.

When Germans refer to travelling people they call them 'Roma' or 'Sinti'. 'Roma' is clearly related to Rom, but who are the Sinti? My German-English dictionary just says 'Sinte' – which leaves me none the wiser.

● According to my copy of *Duden: Deutsches Universalwörterbuch* it is not the Germans but the Sinto themselves who divide the Romany people into *der Rom* and *der Sinto*.The 'Sinto' are the Romany of German origin: the 'Rom' is the name for the Romany from other lands. Most Germans seem to use the words together to show respect – anything to avoid *Zigeuner* which isn't seen as a compliment, my wife informs me.

Stuart Fellows
Essen, Germany



Romany woman: roaming the countryside in search of etymologists.

● There are actually three major groups of the people commonly called 'gypsies': Kale (*gitanes, tziganes*) of Spain, Southern France and Portugal; Roma of the Balkan countries – primarily Romania; and Sinti (*Zigeuner*) of Germany and Central Europe. I cannot find any etymologies for these names.

These groups are thought to have come to Eastern Europe from north-western India between 800 and 1000 AD and to Western Europe as late as the fifteenth century. The word 'gypsy' is derived from Egyptian since it was wrongly assumed that Egypt was their country of origin. They were – and still are – persecuted because they have their own language and culture and many have a nomadic lifestyle. Nazi Germany killed thousands of Sinti and there have been recent attacks on Roma living in Romania.

Conrad Borovski
Menlo Park, US

What evidence is there that children vaccinated against measles, mumps and rubella at an early age will enjoy lasting immunity? What is the risk of their developing these diseases at a later age, when they can be more serious?

● Contrary to the answer given in **NI 271** this important question cannot be fully answered until about 2030, when the first generation of vaccinees reach old age. Studies to date show that most, but not all, of those receiving measles and rubella vaccines retain measurable antibodies for over 20 years. Mumps vaccine only became available in 1988.

Most of the detailed long-term studies have involved rubella vaccines with the specific aim of ensuring that girls vaccinated at puberty retained this protection into their childbearing years. Although up to nine per cent were found to have lost circulating antibodies after three to five years, more detailed studies suggest that many have developed cellular protection against infection.

However, the question overlooks the fact that the main purpose of immunizing infants against measles, mumps and rubella viruses is to break the chain of transmission and to eliminate the risk of infection to anyone.

In the expectation and hope that this programme will be successful, there will be no risk to elderly vaccinees because there will be no risk of infection.

Dr Helen Zealley and Dr Martin Bull
Edinburgh, Scotland

AWAITING YOUR ANSWERS

What proportion of Muslim women cover their faces in public? Is the practice currently increasing? And do women who cover their faces suffer any discomfort or health problems?

Sandra Mariner
Taunton, England

How would the introduction of a single European currency affect countries of the South?

Isabel Milner
London, England

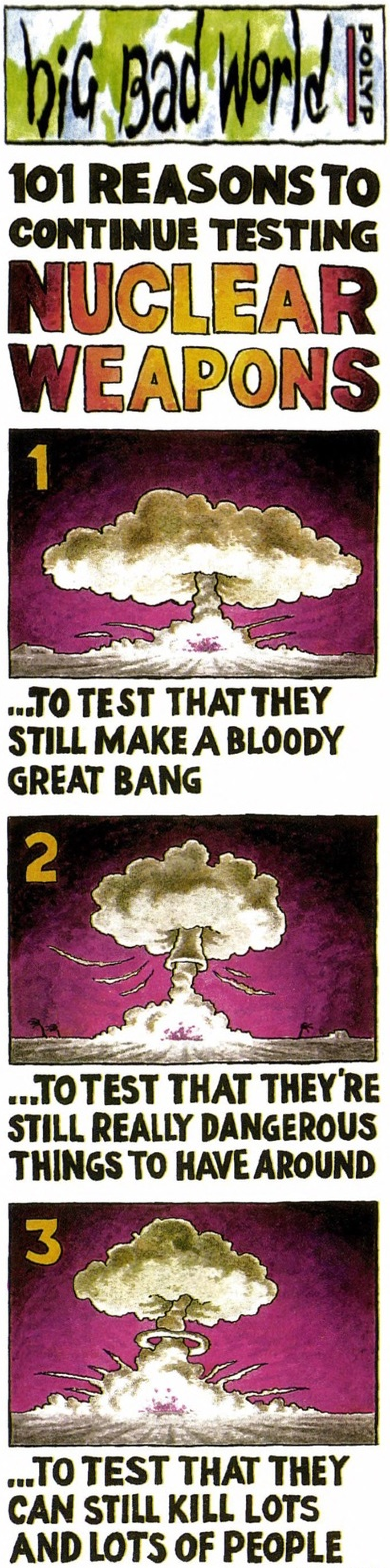
Given that the profit from slave labour in today's terms is a staggering $187,500 million, is there any legal precedence for this money to be repaid in some way as a legacy to the living descendants of such slaves?

Lloyd Jeffers
Worthing, England

Are there any cultures in the world where there is never any reason to exchange gifts?

James Phillips
Wigston, England

IF YOU HAVE ANY QUESTIONS OR ANSWERS PLEASE SEND THEM TO **CURIOSITIES, NEW INTERNATIONALIST, 55 RECTORY ROAD, OXFORD OX4 1BW, UK,** OR TO YOUR LOCAL NI OFFICE (SEE INSIDE FRONT COVER FOR ADDRESSES).


big Bad World
POLYP
101 REASONS TO CONTINUE TESTING NUCLEAR WEAPONS
1
...TO TEST THAT THEY STILL MAKE A BLOODY GREAT BANG
2
...TO TEST THAT THEY'RE STILL REALLY DANGEROUS THINGS TO HAVE AROUND
3
...TO TEST THAT THEY CAN STILL KILL LOTS AND LOTS OF PEOPLE

CONTINUED ON PAGE 53

ENDPIECE

Hidden fist hits the buffers

As the World Bank and IMF meet for their annual conference in Washington, **Duncan Green** looks at their record in Latin America since the debt crisis erupted 13 years ago.

T*HATCHERISMO* has failed. Since 1982 the debt crisis in Latin America has swept aside existing economic orthodoxies. For 13 years market forces have blown at gale force through the region's economies. In this 'silent revolution' an alliance of local élites, transnational corporations and the mighty IMF and World Bank have privatized thousands of state companies, deregulated the banks, removed trade barriers, buried labour rights, axed state spending and sacked hundreds of thousands of state employees. Is is now possible to assess their record and see the full extent of their failure.

Unimpressive record: the state of the roads in San Christobal, Chiapas, Mexico.

DAVID RANSOM

Even in the free-marketeers' preferred safe haven of economic abstractions the record is unimpressive. Economic growth has barely kept up with rising population. An investment collapse has left the region burdened with a crumbling infrastructure of potholed roads, electricity blackouts and water shortages which will take decades to make good. The sole unalloyed success has been in getting inflation down to single, or at most double figures across the continent.

In human terms the failure has been far more profound. Adam Smith's benign market forces have in practice become an 'invisible fist', inflicting terrible damage on the poor. By 1993, 60 million more Latin Americans had been driven below the poverty line, bringing the total to nearly half of the population.

The deterioration in the quality of life is as much psychological as material, but no less painful for that. Adjustment has brought new levels of anxiety into millions of lives by generating more insecure, part-time or informal-sector jobs. Cuts in social services have placed even greater burdens on women, who must now juggle the increased demands of workplace and home, when the already inadequate level of state support has been further reduced. Their families and communities are collapsing around them as crime and social disintegration have topped the list of public concerns in many Latin American societies.

Not everyone has lost out, of course. The Latin American élite has snapped up some rich pickings in the fire-sale of privatization, boosting the number of Latin America's super-rich billionaires from 6 in 1987 to 42 in 1994. What remains of the middle class is able to enjoy everything from Apple Macs to Big Macs as economies open up to overseas trade and investment.

The official response to growing poverty and inequality has been a swing towards a 'kinder, gentler' form of *Thatcherismo.* Poverty relief is back in vogue as the World Bank acknowledges that no country is likely to make the grade saddled with an illiterate, undernourished workforce. Oxfam is unimpressed with the Bank's change of heart, criticizing its failure to make income redistribution an essential part of any poverty-reduction strategy and arguing, in a report released last year, that 'simply bolting on social-welfare provision to wider adjustment policies which are themselves exacerbating poverty does not amount to a poverty-reduction strategy'.

But one piece of Thatcherite rhetoric is still flourishing south of the Rio Grande. Remember TINA – There is No Alternative? 'Neoliberals', as the free-marketeers are known in Latin America, routinely dismiss their critics as economic dinosaurs bereft of alternative ideas, and accuse them of wanting to return to the failed models of the past. Even some of neoliberalism's most trenchant critics confess themselves at a loss when asked what they would do instead.

They need not be so gloomy, for the raw material for alternative economic models is all around. Look at history, where every single successful economy (except the first, Britain) has industrialized by protecting its fledgling industries – a policy anathema to the World Bank and IMF.

Look at Asia (despite **NI**'s recent attempt to rubbish the 'Asian Miracle'). Here you will find a country with the most equal distribution of income in the world, whose exports rose 100-fold from 1965-87 without ever becoming a member of GATT, which uses a strong state to control the activities of foreign investment to the benefit of local industries, which carried out a radical agrarian reform and boasts numerous highly efficient state companies. The name of this apparently progressive utopia? Taiwan.

But the left cannot bring itself to learn from a country run by such an undoubtedly repressive government. On the other side of the argument, the World Bank and other neoliberals insist on portraying Taiwan and other Asian 'tigers' as paragons of the free market, thereby missing the point that success in Asia has been built on high degrees of efficient state management of the economy.

Finally, those seeking alternatives at the top should look downwards, to the Latin American grassroots, where local organizations are getting on with the business of developing new models of just and sustainable development. Such initiatives take a small-is-beautiful approach, basing their work on community needs. In time their experiments could become the foundation for the kind of 'people-centred adjustment' the region so desperately needs.

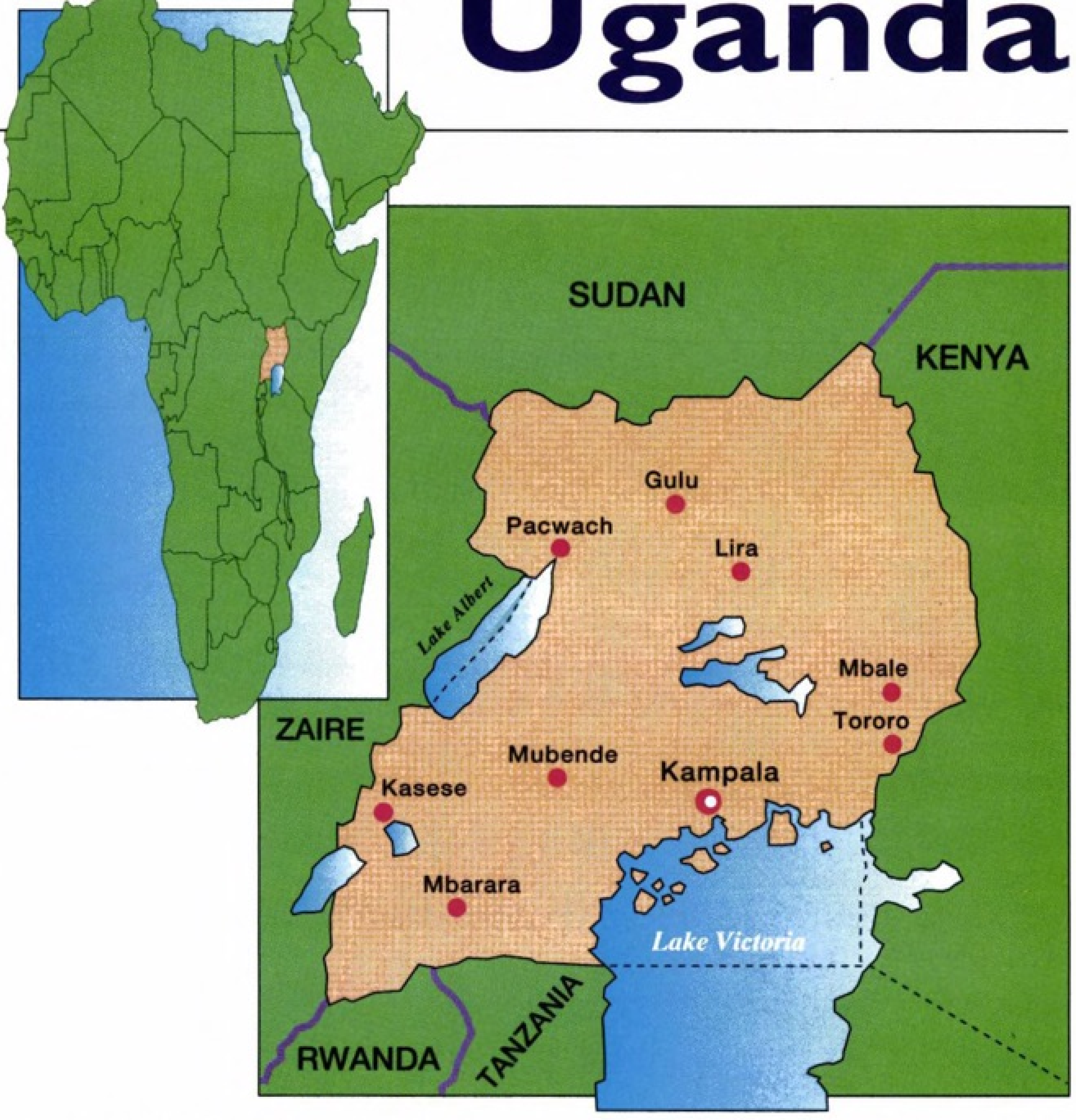
Will such alternatives be grasped in time? The signs are not good. Latin America's silent revolution required the catastrophe of the debt crisis and the unceasing arm-twisting of the IMF and World Bank to bring it about. History suggests that another such trauma will be required to achieve another sea-change in economic and political thinking.

For the half of all Latin Americans already submerged beneath the poverty line the trauma is already here, but they may have to wait until it harms the region's élites and powerful interests abroad before real change becomes possible. Is it really too much to ask that those currently in charge of the region's destiny, whether they be in Latin America or in the economic powers of the North, learn from history and make the necessary changes *before* the next disaster occurs? ■

Duncan Green is author of *Silent Revolution: The Rise of Market Economics in Latin America*, has just been published by Cassell in Britain and by Monthly Review Press in the US.

Country profile

Uganda



THE NILE MANSIONS once struck terror into the hearts of Ugandans. It was there that Idi Amin's torturers exercised their peculiar tastes in violence. Now the luxury Nile Hotel, its rooms are likely to accommodate World Bank or IMF visitors wielding instruments of economic reform.

Times have changed greatly since the National Resistance Army entered Kampala in January 1986, bringing Yoweri Museveni and the National Resistance Movement (NRM) to power. Armed rebellion has been subdued – though the small Sudan-backed Lord's Resistance Army still conducts savage cross-border attacks on hapless villagers. In Kampala, the police have reclaimed law and order from the military. The capital is a pleasant, modern city.

Dismissed as a disaster area after the extreme violence of the Amin and Obote decades, Uganda is applauded for hauling its economy from the sickbed and its population out of an era of gross disregard for human rights. Amnesty International is still concerned about arbitrary arrests following rebel action, and some harassment of opposition politicians and newspapers, but it acknowledges the gains already made – and Uganda acceded last June to the International Covenant on Civil and Political Rights.

Uganda is the darling of the IMF, having followed its recommendations and achieved an annual growth rate of nearly six per cent over the past nine years. Aid donors have also been impressed, pledging $850 million last year against the $500 million asked for. Asians expelled by Amin have been invited back and there has been an inflow of investment capital.

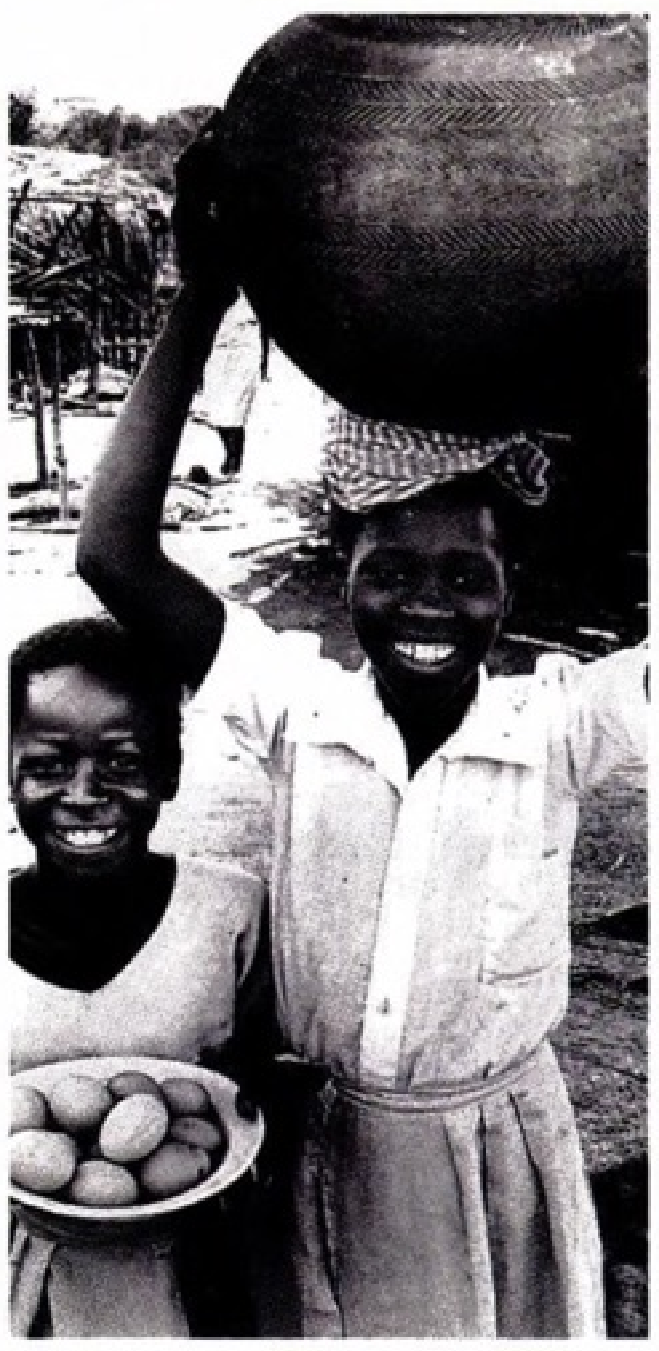
Yet Uganda remains a very poor country, burdened with vast international debt. The sense of progress is by no means felt in all parts of the country. People complain of a widening gap between the beneficiaries of new policy and the sizeable proportion of the population who are getting poorer. Much of the north remains a Cinderella region.

The NRM has resisted pressure to reinstate multi-party democracy, pursuing its idea of governance by a popular front incorporating different shades of political opinion. Parties can operate but are not represented in government. President Museveni's argument is that premature multi-party democracy will reproduce the tribal fragmentation all too familiar in the old Uganda and elsewhere in Africa. He sees the NRM as enabling Ugandans to move away from crumbling tribal traditions and embrace new principles of democracy and modernization.

In June the NRM Constituent Assembly voted to defer the return to multi-party democracy for a further five years, after which a referendum will be held. At the local level Resistance Committees – elected by and accountable to the communities they serve – are encouraged to mobilize resources to deal with local problems, attacking the dependency syndrome that often undermines development. While they need more training to realize their full potential, they can bring an unprecedented degree of democracy to local government, and an opportunity for ordinary people to develop democratic practice and self-reliance. ■

Anthony Swift

AT A GLANCE


ERIC L WHEATER

Leader President Yoweri Kaguta Museveni
Economy GNP per capita: $170 – the seventh lowest in the world *(US $23,240)*
Monetary unit: Ugandan Shilling
Main exports: Coffee (70% of total), cotton. New exports - hides, maize, sesame and fish
Main imports: Capital goods, manufactured goods, foodstuffs, fuels
External debt: $3 billion
People 19.3 million
Health Infant mortality 114 per 1,000 live births *(Australia 7 per 1,000)*. An estimated one in five (nine per cent of the general population) of the sexually active population is infected with HIV. Encouragingly, though, rates of infection among women attending antenatal clinics have been falling since 1992.
Culture Most Ugandans come from the integration of various ethnic groups, mainly the Baganda, Bunyoro and Batoro
Religion: Christian (Catholic and various Protestant sects) 50%; traditional (mostly animist) 40%; Muslim 10%
Languages: English is the official language but Nilotic languages are spoken in the north and Bantu in the south. The most common are Kiswahili, Luganda and Luo.

***Sources:** New Africa Year Book 1995-96; Africa Review 1995; The Statesman Year Book 94-95; The State of the World's Children 1995; Amnesty International; Oxfam; AIDS Analysis Africa.*

Previously profiled October 1983

NI star rating

EXCELLENT	★★★★★
GOOD	★★★★
FAIR	★★★
POOR	★★
APPALLING	★

STAR RATINGS

INCOME DISTRIBUTION
★★
Structural adjustment is widening the gap.
1983 ★★★

LITERACY
★★
48% However, primary-school enrolment is 80%
1983 ★★★

SELF-RELIANCE
★★
Uganda is hobbled by an onerous debt burden and has a very narrow manufacturing base. Its debt servicing to exports ratio is three times the IMF estimate for sustainability.
1983 ★★

FREEDOM
★★★
Ugandans are a lot freer from tyranny and armed insecurity but there have been efforts to control the press and political opponents.
1983★★

POSITION OF WOMEN
★★★
Realizing women's aspirations is seen as part of modernization and a woman is vice-president. New opportunities but still a long way to go.
1983 ★★

LIFE EXPECTANCY
★
42 years. Currently the lowest life expectancy in the world, largely due to AIDS.
1983★★

POLITICS

NI ASSESSMENT ★★★★
The NRM Government deserves credit for pulling Uganda out of the horror of the Amin and Obote years – and for its moves against sectarianism and towards local democracy. But its economic policies may work against its claim to be acting in the interests of all Ugandans at a time when it is resisting pressure for multi-party democracy.

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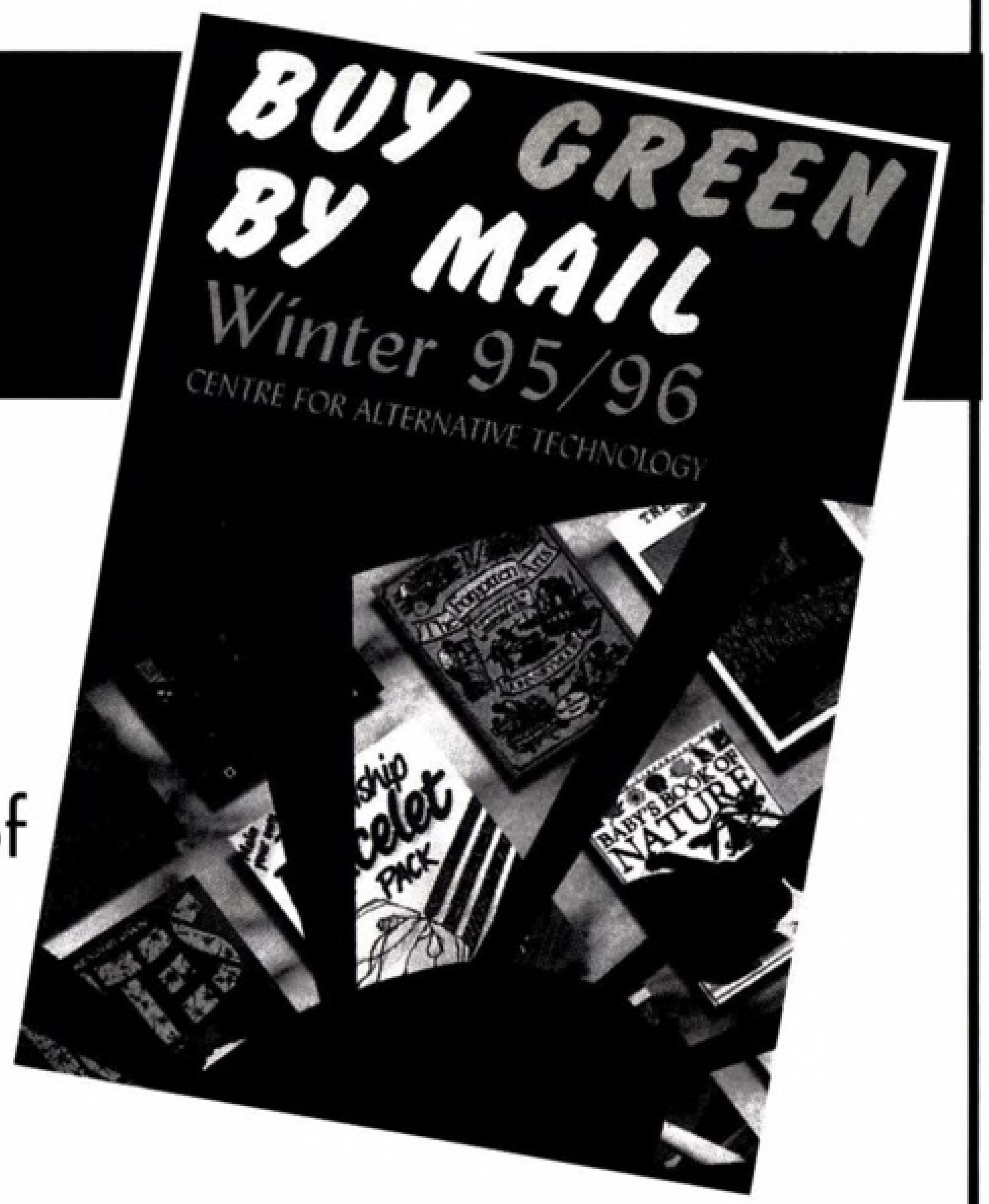

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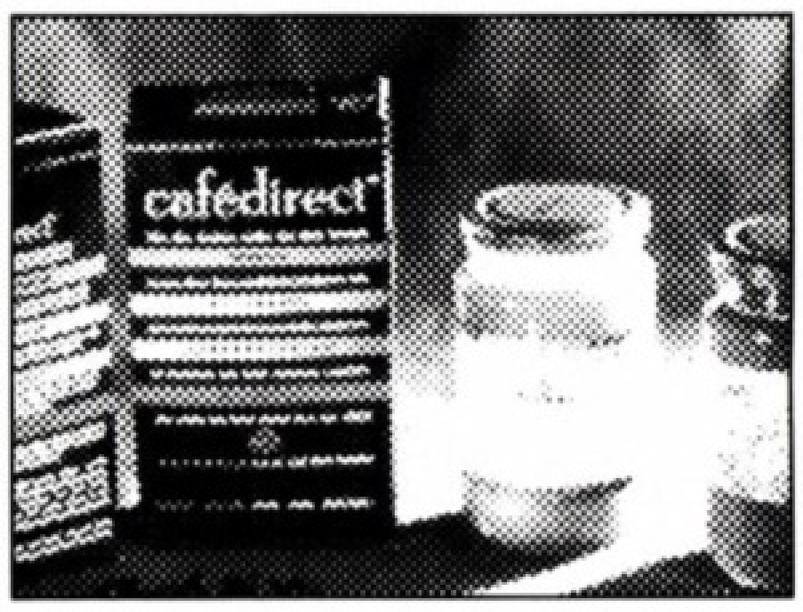

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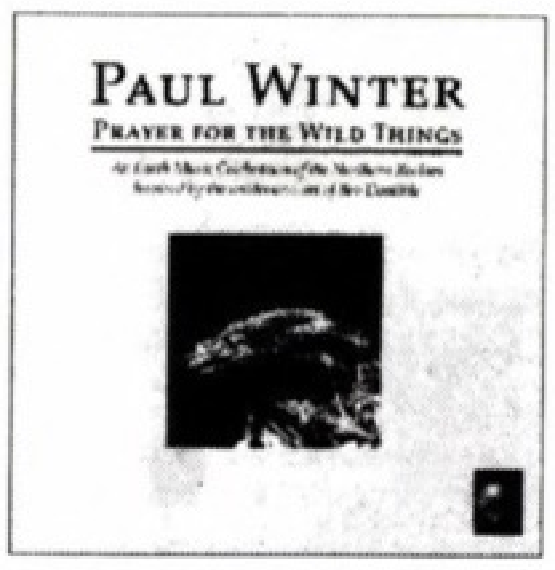

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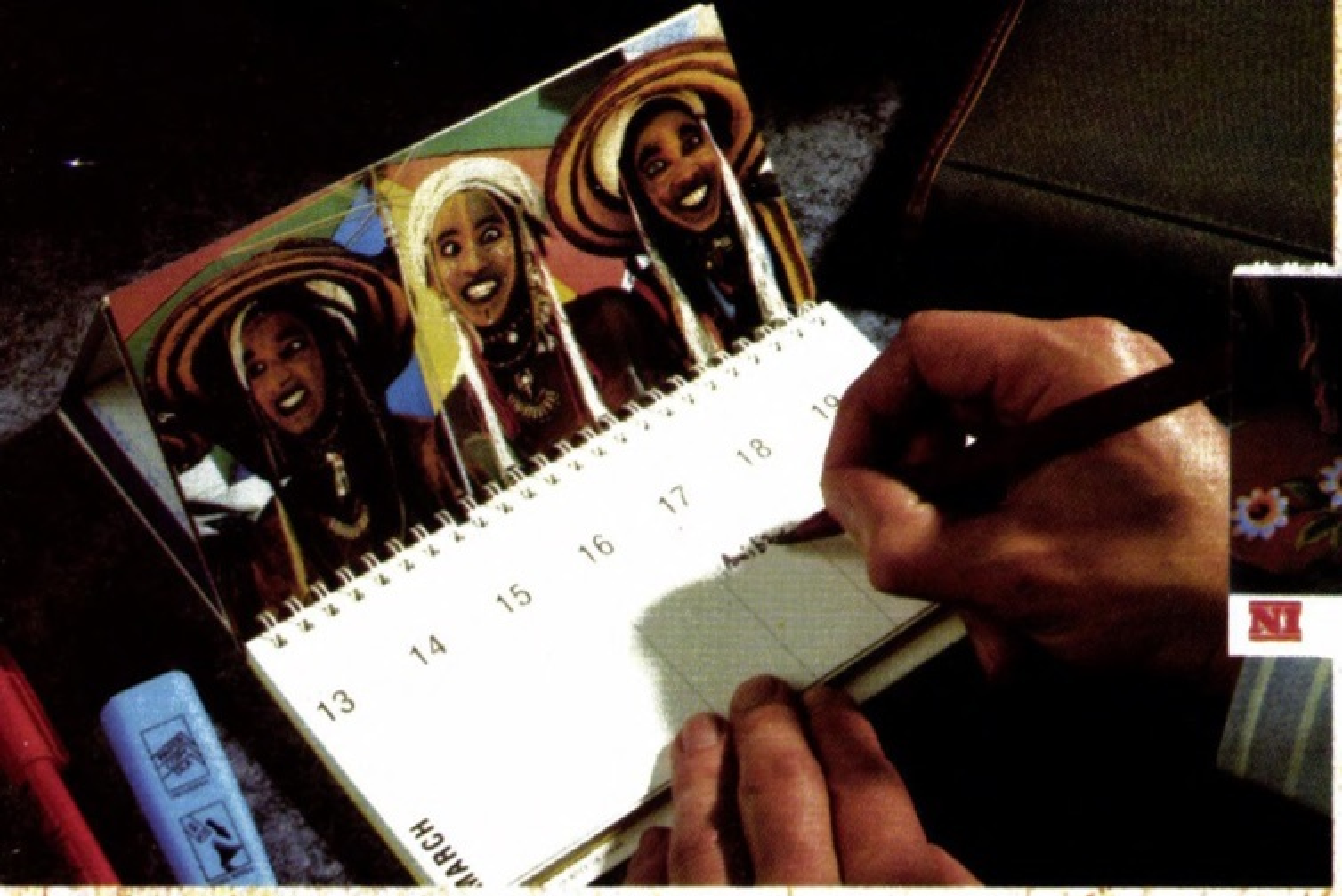

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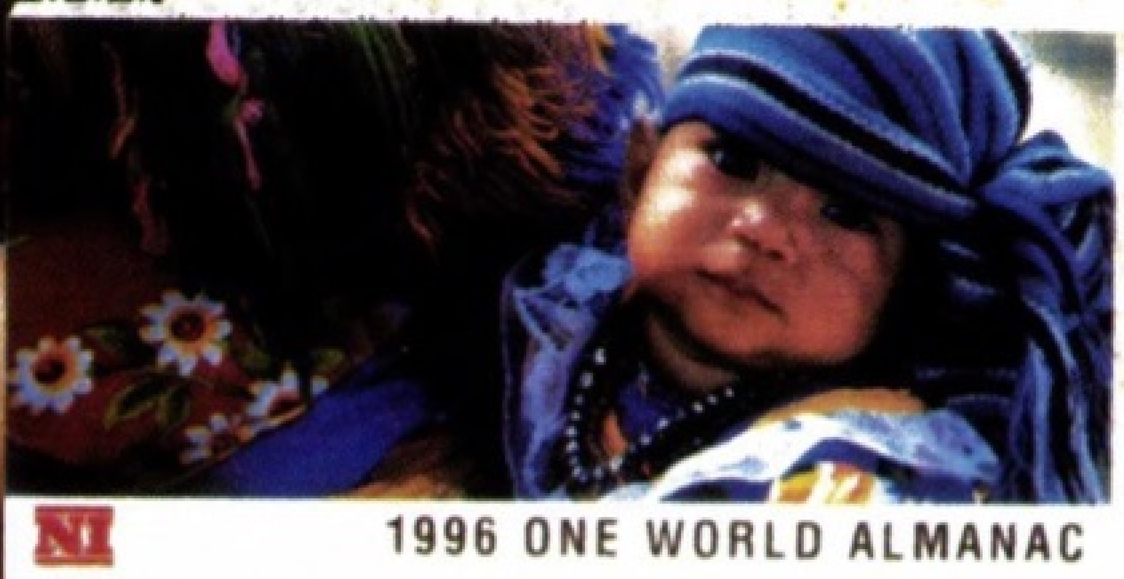

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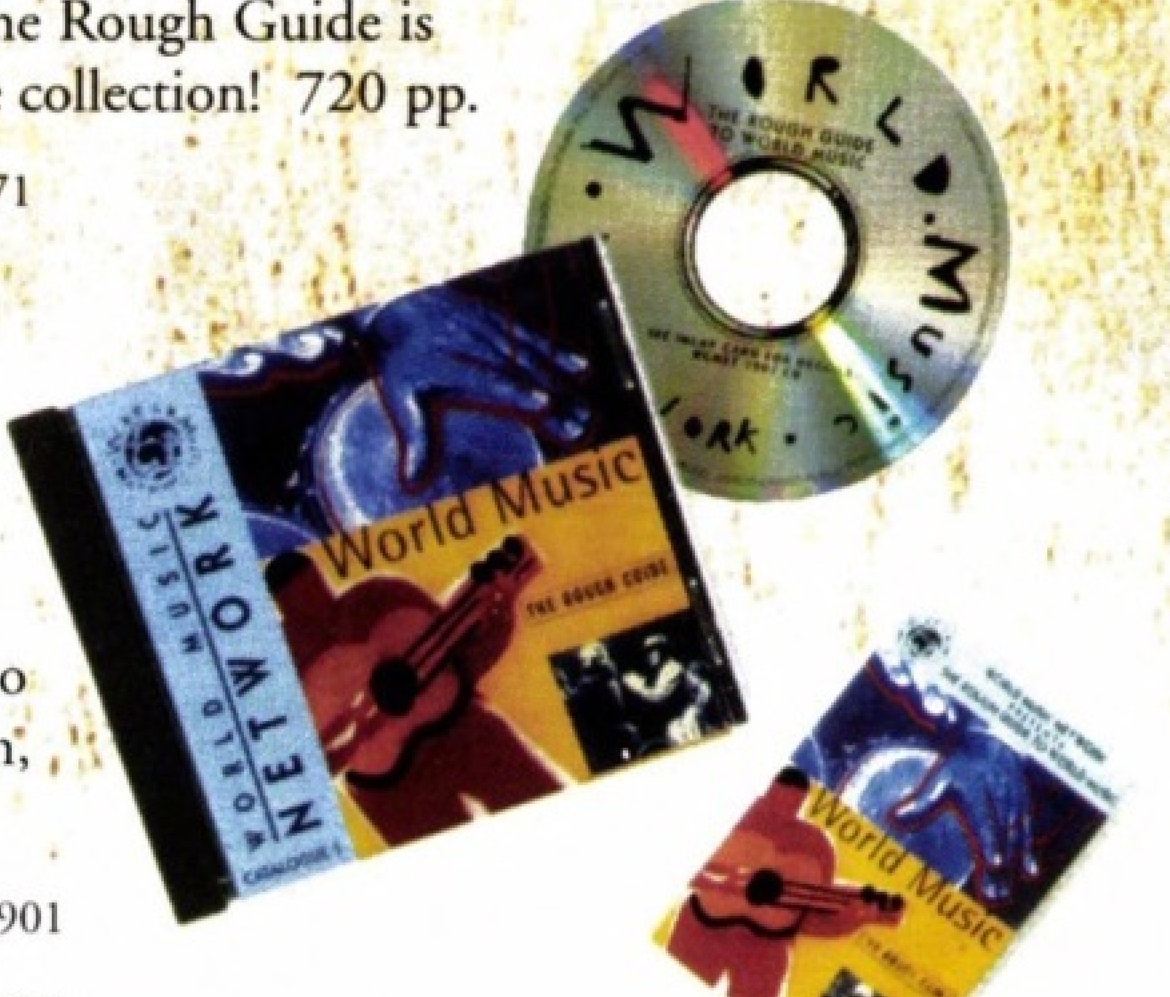

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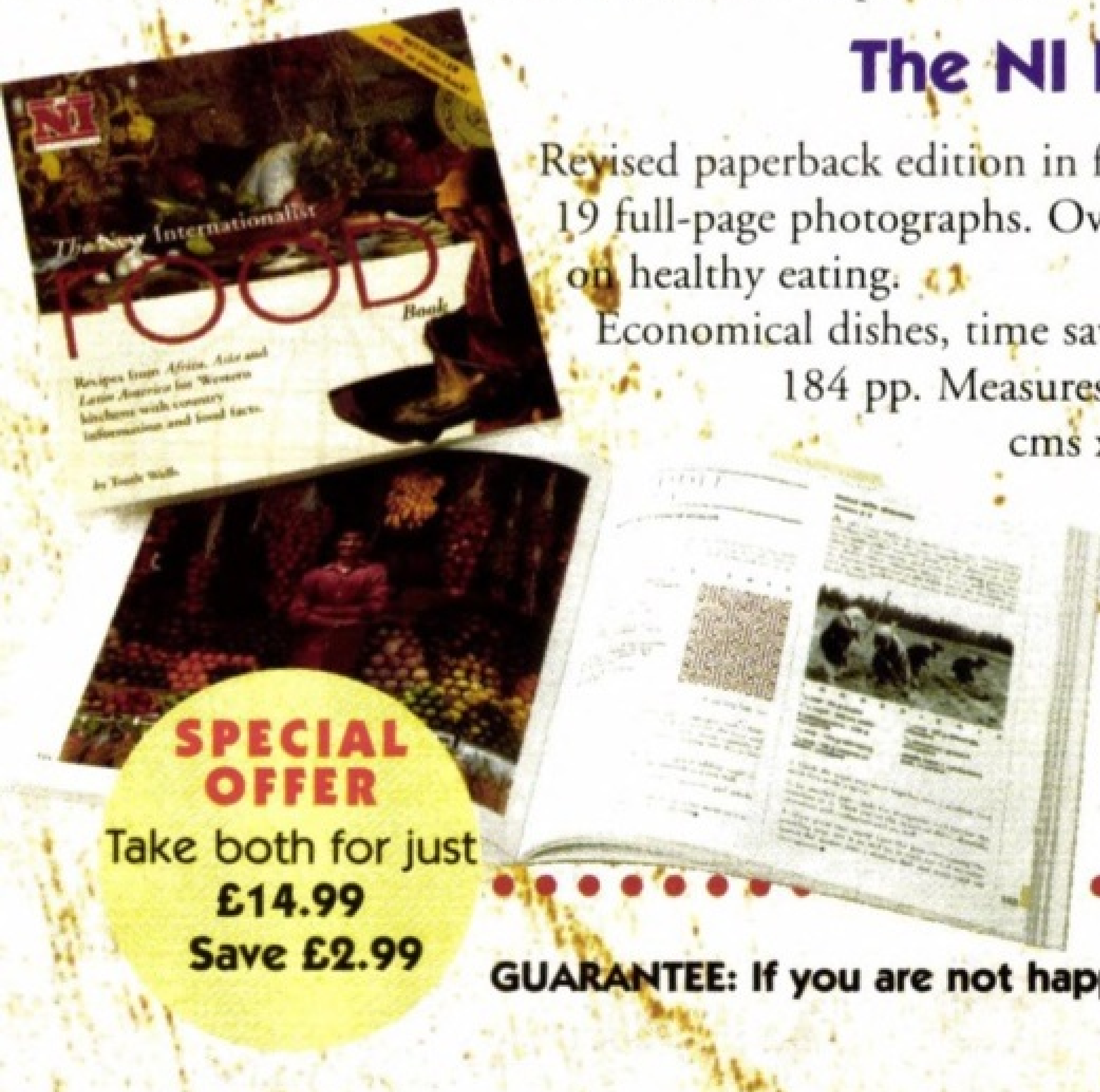

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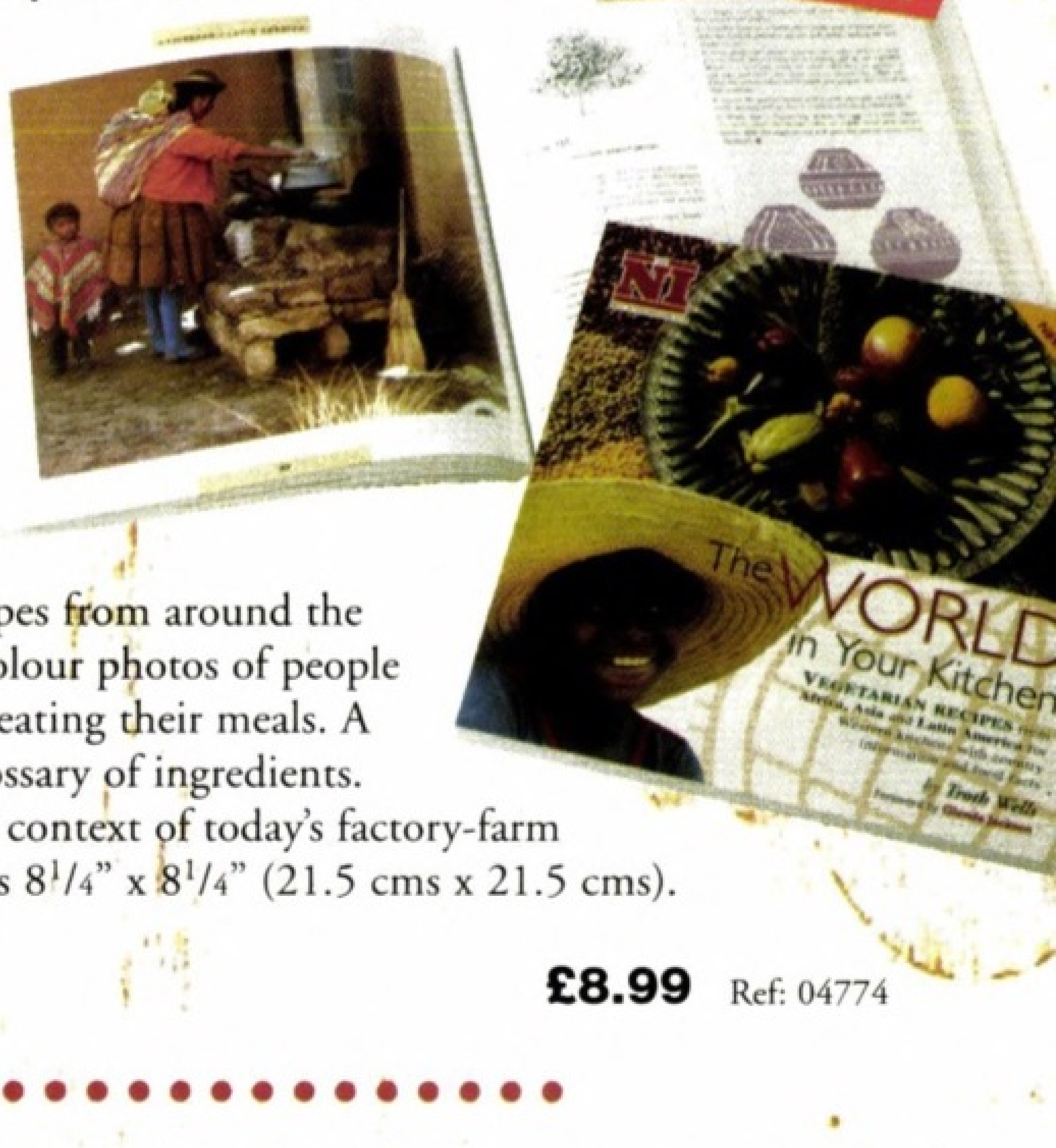

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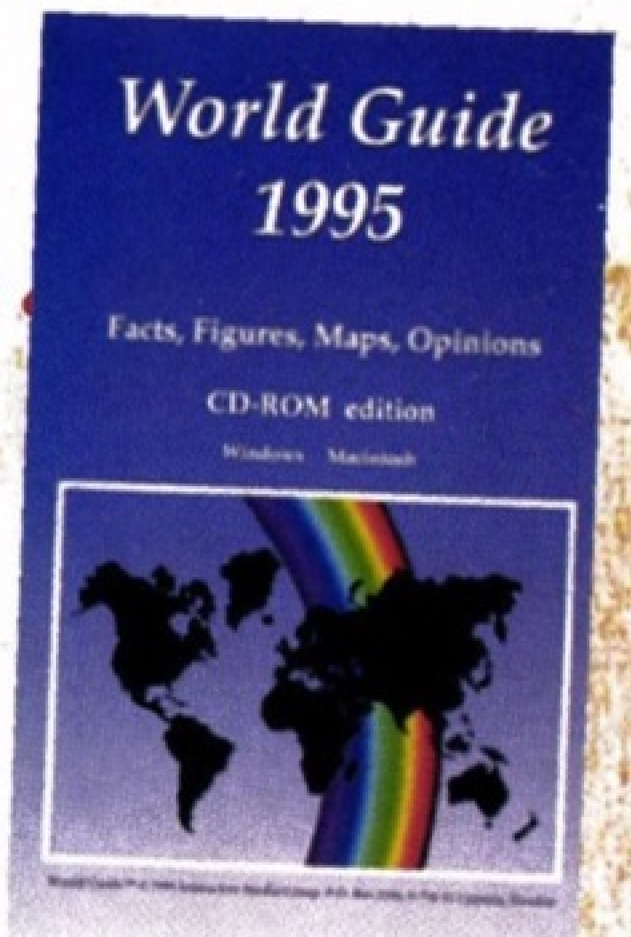
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